Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/4	7/2042
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	02/1	7/2012
BRIGHTS	TAR OF LAFAYETTE IND	IANA	ΓΙVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 000	Initial Comments		N 000			
	This visit was for an in licensure survey.	nitial home health state				
	Survey dates: Februa	ary 15, 16, and 17, 2012				
	Facility: #012722					
	Medicaid Vendor: N/A	4				
	Surveyors: Bridget Boston, RN, PHNS Tonya Tucker, RN, PHNS					
	Census: 7 Skilled 4 Aide only: 2 Homemaker only: 1 Home Vitis: 3					
	Quality Review: Joyce March 1, 20	e Elder, MSN, BSN, RN 12				
	This survey was mod	ified 6/1/12. je				
N 440	410 IAC 17-12-1(a) H administration/manag	- ·	N 440			
		tive control, and lines of gation of responsibility down vel shall be: n writing; and				
	personnel roster and	et as evidenced by: gency documents and interview, the agency failed el providing services for the				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE INC	DIANA 25 EXEC	DDRESS, CITY, STATE CUTIVE DRIVE SUIT TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 440	chart reviewed.  The findings include:  1. A review of the onthe director of nursing "Field Staff" and listenurses, licensed practicular and listenurses, licensed practicular and listenurses, licensed practicular assistants, hicompanions, physical all together, as equal responsibility. The omedical social worke  2. A review of the peevidence physical and were employees or cagency. The employmedical social worke the organizational ch	ganizational chart in 1 of 1  ganizational chart identified g / administrator directed the ed the disciples registered ctical nurses, certified ome health aides, al and occupational therapists s, without any delineation of chart failed to include the r.  ersonnel roster failed to d occupational therapists ontract employees of the ee roster did include a r that was not identified on art.  ebruary 15, 2012, the ed the agency did not and that all physical,	N 440			
N 444	Rule 12 Sec. 1(c) Ar home health agency time at the home hea as its administrator. also be the supervision	) Home health agency gement  n individual need not be a employee or be present full lith agency in order to qualify The administrator, who may ng physician or registered bsection (d), shall do the	N 444			

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	DNSTRUCTION		E SURVEY PLETED
	012722	B. WING		02	/17/2012
ROVIDER OR SUPPLIER	DIANA 25 EXEC	CUTIVE DRIVE SUIT			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
(1) Organize and di	rect the home health	N 444			
Based on clinical reconstruction, and a observation; and inte	ord, personnel record, agency document review; rview, the administrator				
The administrator personnel providing sidentified by delegations.	failed to ensure all services for the agency were on of responsibility on the				
patient contact, home completed a compete	e health aides successfully ency evaluation program in 6				
budgeting and accou fiscal year ending 12	nting system for the current /31 for 1 of 1 fiscal year				
5. The administrator criminal history or exapplied for within 3 brand included a search	failed to ensure a limited panded criminal history was usiness days of employment h back to the employee's				
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page (1) Organize and directly and agency's ongoing fur  This RULE is not me Based on clinical receive hospital record, and a observation; and intefailed to organize and functions.  The findings include:  1. The administrator personnel providing sidentified by delegation organizational chart in (See S 440)  2. The administrator patient contact, home completed a competed of 6 home health aided and S 596).  3. The administrator budgeting and accountiscal year ending 12 reviewed. (See S 444)  4. The administrator met the requirements  5. The administrator criminal history or exapplied for within 3 be and included a searce.	CONTIDER OR SUPPLIER  STREET A  25 EXECUTAR OF LAFAYETTE INDIANA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  (1) Organize and direct the home health agency's ongoing functions.  This RULE is not met as evidenced by: Based on clinical record, personnel record, hospital record, and agency document review; observation; and interview, the administrator failed to organize and direct the agency's functions.  The findings include:  1. The administrator failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed. (See S 440)  2. The administrator failed to ensure, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed (See S 446)	SOVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE,  AR OF LAFAYETTE INDIANA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  (1) Organize and direct the home health agency's ongoing functions.  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The administrator failed to ensure a limited criminal history or expanded criminal history was applied for within 3 business days of employment and included a search back to the employee's	CONTIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905  SUMMARY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 2  (1) Organize and direct the home health agency's ongoing functions.  This RULE is not met as evidenced by: Based on clinical record, personnel record, hospital record, and agency document review; observation; and interview, the administrator failed to organize and direct the agency's functions.  The findings include:  1. The administrator failed to ensure all personnel providing services for the agency were identified by delegation of responsibility on the organizational chart in 1 of 1 chart reviewed. (See S 440)  2. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	-	
BRIGHTS	TAR OF LAFAYETTE INC	DIANA	UTIVE DRIVE SUI	TE 2A		
(V4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	TTE, IN 47905	PROVIDER'S PLAN OF CO	DRRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 444	Continued From page	e 3	N 444			
	of job orientation for documentation evide qualified for 1 of 1 so (See S 458)  6. The administrator employees had a phy of first patient contact was free from communities reviewed (See 7. The administrator Tuberculosis screening was completed upon	vsical exam within 180 days t that identified the employee unicable disease for 11 of 12 S 462) failed to ensure ngs with a two step Mantoux hire if the employee did not				
	twelve months or a c	reactors for for 8 of 12 files				
	maintained in separa	failed to ensure the records of employees were te medical file and treated as 12 employee files reviewed.				
	contracts included all	failed to ensure written I the required items for 1 of 1 tract reviewed. (See S 478)				
	available personnel f	or failed to ensure the maintained and made iles for review for 1 of 1 herapist file reviewed. (See				
	developed and imple	or failed to ensure the agency mented a policy requiring a 5 ge for 1 of 1 agency. (See N				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	UTIVE DRIVE SU ITE, IN 47905	ITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
N 444	Continued From page	· 4	N 444		
	family or legal repress patient's rights as per records reviewed. (Set 13. The administrato patients were informed grievances regarding be furnished, lack of anyone providing servagency and that the prot be subjected to di	d of the right that their entative may exercise the mitted by law for 5 of 5 ee S 496)  r failed to ensure that d of their right to voice treatment that is or failed to respect for property by			
	or their representative	d of the right that the patient has the right under Indiana ent's clinical record for 5 of			
	were informed that the investigate complaints patient's family or legatreatment or care that and/or the lack of resproperty by anyone further the home health ago the existence of the complete.	r failed to ensure patients e home health agency must is made by the patient or all representative regarding it is or fails to be furnished pect for the patient's urnishing services on behalf gency and document both complaint and the resolution of 5 records reviewed.			
	in 1 of 1 record review	adequately met in the home ved with patient harm ial to affect all the agency's			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE INI	DIANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT ETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 444	patient's needs in the reviewed with patient	or failed to ensure e available to meet the e home in 1 of 1 record t harm. (See S 522)	N 444			
	plan of care was dev required items for 2 c in which the patient v service. (See S 524)					
	physician was notifie condition or changes patient's condition in	1 of 1 clinical records whose care resulted in				
	records included a no patient records revie	or failed to ensure the clinical ursing plan of care for 3 of 3 wed of patients receiving ly services. (See S 533)				
	registered nurse made to identify the patient	or failed to ensure the de an initial assessment visit ts' immediate care needs as policy for 3 of 5 clinical record 0)				
	registered nurse esta	or failed to ensure the ablished a plan of care for 4 reviewed. (See S 542)				
	registered nurse info changes in the patier could affect the patier	or failed to ensure the rmed the physician of nt's condition or changes that ent's condition in 1 of 1 wed of patients whose care arm. (See S 546)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	JTIVE DRIVE SU TE, IN 47905	JITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
N 444	Continued From page	e 6	N 444		
	which were obtained evaluation of the patie in 3 of 3 clinical record which received skilled 25. The administrator physical therapist con assessment visit with referral as required by clinical records review physical therapy only.  26. The administrator social worker provided 1 record reviewed with (See S 572)  27. The administrator documentation evider contact, home health completed a competer.	ed out the physician orders by the agency for the ent for home health services ds reviewed of patients who discreviewed of patients who discreviewed. (See S 547)  If failed to ensure the inpleted the initial in forty eight hours of y agency policy in 2 of 2 wed of patients receiving. (See S 562)  If failed to ensure a qualified discrevices as ordered in 1 of the orders for a social worker.  If failed to ensure inced that, prior to patient			
N 446	410 IAC 17-12-1(c)(3 administration/manag		N 446		
	Rule 12 410 IAC 17-1	2-1(c)(3)			
	the supervising physic required by subsection	ninistrator, who may also be cian or registered nurse n (d), shall do the following: personnel and ensure tion and evaluations.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02	/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU TE, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N 446	document review and failed to ensure, prior health aides successf competency evaluation health aide files review.  Findings include:  1. During an interview the Director of Nurses all competency evaluated Aides in facilities. She does not test the aide or passive, and the nualdes to complete ran order for a therapist to complete ran order for a therapist to the agency respective of the agency	t as evidenced by: ecord, clinical record, and interview, the administrator to patient contact, home fully completed a on program in 6 of 6 home wed (G, H, I, J, K, and L).  If you on 2/15/12 at 12:50 PM, is indicated she completed ations for the Home Health the further indicated that she is on range of motion, active curses are not to order any igge of motion without an to evaluate the patient.  If PM, employee N, the ter, indicated the governing requested the Indiana State to close the previously in agency and then they he health agency provisional did received that license is 11. She indicated the tere presented for review he agency and she did not he agency with a new license health Aide Continuing hetency Evaluation Program health Aides prior to providing did have the following areas all completion of a	N 446			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			23.25.110.		
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
BRIGHTS	TAR OF LAFAYETTE IND	IANA	UTIVE DRIVE SU	JITE 2A	
			TE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
N 446	N 446 Continued From page 8		N 446		
	completion of a comp	etency evaluation."			
	Competency Program will access and docur of each staff member care, treatment, or se who provides direct of competency assessmas part of orientation, and regulations."  5. Employee files G, document titled "Com Check List for Certifies skills included on the Temperature - digital temporal, tympanic. 2 apical. 4) Blood Press shower / tub bath. 7) oral care. 10) shampourinal, bedpan, bedsic bed to chair, chair to ambulation, and othe motion. 14) assistive 15) positioning. 16) m Miscellaneous skills: Urinary catheter care observe / record intak 27) Meal Prepara low sodium, low chole was to be initialed an evaluating the skill. Tat the bottom of the pobservation, "D" for dispecial training. The motion.	thermometers, oral, axillary, 2) Pulse - radial. 3) Pulse - sure. 5) respirations., 6) bed bath. 8) skin care. 9) bo. 11) toileting / elimination: de commode. 12) transfer: standing, assist with r. 13) assists with range of devices: walker, cane, other. haking occupied bed. 17) Medication reminder, gastrostomy site care, se / output, other, and other. tion: feeding, diabetic diet, esterol / fat diets." The form d dated by the individual			
	<ol><li>Personnel file G, c patient contact 12/14/</li></ol>				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	012722	B. WING		0.0	0/47/2042
				02	2/17/2012
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
BRIGHTSTAR OF LAFAYETTE INDI	ANA	CUTIVE DRIVE SUIT	ΓE 2A		
		TTE, IN 47905			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 446 Continued From page	9	N 446			
evidenced the docume Assessment Skills Che Nursing Assistant" that evaluated on 6/21/11, 1/10/12 (after patient of failed to evidence the range of motion, 2) shis shampoo, and 4) meat sodium, low cholesters evidenced the aide was in an additional task at flush" that was not dat scope of practice of the 7. Personnel file H, dat patient contact 12/13/19 evidenced the docume Assessment Skills Che Nursing Assistant" that evaluated on 6/7/11, 6 and 12/30/11 (after first document failed to evit evaluated on 1) range bath, 3) shampoo, 4) the urinal, bedpan, or bed meal preparation of a cholesterol / fat diet. The aide was evaluated additional task and wriflush" on 12/13/11 and 12/20/11. These tasks practice of the home had seessment Skills Che Nursing Assistant" while which is the difference of the docume Assessment Skills Che Nursing Assistant" while which is the side was evaluated additional task and wriflush on 12/13/11 and 12/20/11. These tasks practice of the home had seessment Skills Che Nursing Assistant" while which is the side was evaluated and the side was evaluated and the side was evaluated additional task and wriflush on 12/13/11 and 12/20/11. These tasks practice of the home had seessment Skills Che Nursing Assistant while which we will be side of the	ent titled "Competency eck List for Certified to documented skills were 8/31/11, 12/7/11, and contact). The document aide was evaluated on 1) ower or tub bath, 3) I preparation, diabetic, low of /fat diets. The document as evaluated as competent and written in as "catheter ed. This task is not in the e home health aide.  ate of hire 5/18/11 and first 11 with patient # 4, ent titled "Competency eck List for Certified to documented skills were //8/11, 8/31/11, 12/13/11, est patient contact). The dence the aide was of motion, 2) shower or tub oileting or elimination, side commode, and 5) diabetic, low sodium, or low The document evidenced das competent in an extension as "Foley catheter I"basic wound care" are not in the scope of the ealth aide.  The of hire 10/10/11 and first 11 with patient # 4, ent titled "Competency"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			SURVEY	
		012722	B. WING		02	/17/2012
	ROVIDER OR SUPPLIER	IANA 25 EXEC	DDRESS, CITY, STATE	•		
	Г	LAFAYE1	TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
N 446	motion, 2) shower or elimination, urinal, be and 4) meal preparat sodium, or low choles document evidenced competent in an addi "Foley catheter flush' 12/18/11. These task practice of the home  9. Personnel file J, d patient contact 12/24 evidenced the docum Assessment Skills Ch Nursing Assistant" whe evaluated on 11/1/11 document failed to everally evidenced the document, 3) shampoo, 4) urinal, bedpan, or befeeding, or meal preplow cholesterol / fat devidenced the aide win an additional task a catheter flush" and "b 12/24/11. These task practice of the home	s evaluated on 1) range of tub bath, 3) toileting or dpan, or bedside commode, ion of a diabetic, low sterol / fat diet. The the aide was evaluated as tional task and written in as and "basic wound care" on a are not in the scope of health aide.  ate of hire 11/1/11 and first //11 with patient # 4, then titled "Competency neck List for Certified nich documented skills were in 11/9/11, and 12/24/11. The ridence the aide was the of motion, 2) shower or tub toileting or elimination, diside commode, and 4) the aration of a low sodium, or iet. The document as evaluated as competent and written in as "Foley wasic wound care" and dated as are not in the scope of health aide.	N 446			
	patient contact 12/24 evidenced the docum Assessment Skills Ch Nursing Assistant" whe evaluated on 7/8/11, 12/15/11. The docum aide was evaluated on shower or tub bath, 3 elimination, bedpan, a elimination, bedpan, or tub bath, a elimination, bedpan, or tub bath, 3 elimination, bedpan, or tub bath, a elimination, bedpan, or tub bath, a elimination, bedpan, a elimination, a	nent titled "Competency neck List for Certified nich documented skills were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
	ROVIDER OR SUPPLIER	IANA 25 EXEC	DDRESS, CITY, STAT UTIVE DRIVE SUI ITE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 446	competent in an addit "Foley catheter flush" dated 12/15/11. Thes of practice of the hom  11. Personnel file L, of first patient contact 12 document titled "Com Check List for Certifie documented skills we The document failed t evaluated on 1) range bath, and 3) toileting of bedside commode. T aide was evaluated as task and written in as "basic wound care" an	terol / fat diet. The the aide was evaluated as ional task and written in as and "basic wound care" and se tasks are not in the scope	N 446		
N 448	may also be the supe registered nurse required the following: (5) Implement a budg system.  This RULE is not mer Based on policy and conterview, the administ budgeting and accounters accounter the super registered interview.	ement  The administrator, who rvising physician or ired by subsection (d), shall geting and accounting  t as evidenced by:	N 448		

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X				
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED	
		012722	B. WING		02/1	7/2012	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		25 EXECU	JTIVE DRIVE SU	JITE 2A			
BRIGHTSTAR OF LAFAYETTE INDIANA LAFAYET			TE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
N 448	Continued From page	e 12	N 448				
	budgets.  2. The undated policing BrightStar Healthcare states, "Authority and overall, day to day op Healthcare shall be diameter Administrator. The administrator and budgeting.  3. The undated policing Governing Body" statishall be responsible to	y titled "Section 01.01 A e Governing Body By Laws" I Responsibility for the perations of BrightStar elegated to the dministrator shall: ng and accounting system."  y titled "Section 01.01 - es, "The governing body					
N 449	administration/manag Rule 12 Sec. 1(c)(6) also be the supervisir nurse required by sub following:	The administrator, who may ng physician or registered osection (d), shall do the ome health agency meets	N 449				
	hospital record, and a	ord, personnel record, agency document review; rview, the administrator gency met all the					

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU COMPLE		
			A. BUILDING:			
		012722	B. WING		02/17	7/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	ITIVE DRIVE SU TE, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
N 449	Continued From page	e 13	N 449			
	identified by delegatic organizational chart in (See S 440)  2. The administrator the agency's ongoing  3. The administrator patient contact, home completed a compete of 6 home health aide and S 596).  4. The administrator budgeting and account	ervices for the agency were on of responsibility on the of 1 of 1 chart reviewed.  failed to organize and direct functions. (See N 444)  failed to ensure, prior to the health aides successfully ency evaluation program in 6 of files reviewed (See S 446)  failed to implement a noting system for the current 31 for 1 of 1 fiscal year				
5. The administrator failed to ensure a limited criminal history or expanded criminal history was applied for within 3 business days of employment and included a search back to the employee's 18th birthday for 10 of 12 employee files reviewed of employees that required a limited criminal history, employee files contained documentation of job orientation for 12 of 12 files reviewed, and documentation evidenced the social worker was qualified for 1 of 1 social worker file reviewed. (See S 458)  6. The administrator failed to ensure all employees had a physical exam within 180 days of first patient contact that identified the employee was free from communicable disease for 11 of 12 files reviewed. (See S 462)						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE INC	DIANA 25 EXEC	UTIVE DRIVE SUIT	E 2A		
		LAFAYE	FTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 449	Continued From page	e 14	N 449			
	was completed upon have a negative tube twelve months or a clincluded for positive reviewed. (See S 464)	ngs with a two step Mantoux hire if the employee did not reculin test within the previous hest x ray report was reactors for for 8 of 12 files 4) failed to ensure the				
	confidential medical records of employees were maintained in separate medical file and treated as confidential for 12 of 12 employee files reviewed. (See S 466)					
	contracts included all	failed to ensure written I the required items for 1 of 1 tract reviewed. (See S 478)				
	available personnel f	or failed to ensure the maintained and made iles for review for 1 of 1 herapist file reviewed. (See				
	11. The administrator failed to ensure the agency developed and implemented a policy requiring a 5 day notice of discharge for 1 of 1 agency. (See N 488)					
	family or legal repres	ed of the right that their centative may exercise the rmitted by law for 5 of 5				
	patients were informed	or failed to ensure that ed of their right to voice treatment that is or failed to respect for property by				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY IPLETED	
		012722	B. WING		0:	2/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE INC	DIANA 25 EXEC	DDRESS, CITY, STATE CUTIVE DRIVE SUIT TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 449	agency and that the protest be subjected to dispression of the grievances voiced for (See S 500)  14. The administrator patients were informed or their representative law to access the patient's records reviewed.  15. The administrator were informed that the investigate complaint patient's family or leg treatment or care that and/or the lack of resproperty by anyone from the home health at the existence of the confidence of the complaint for 50 (See S 514)  16. The administrator patient's needs were in 1 of 1 record reviewed in the patient's needs in the reviewed with patient 18. The administrator plan of care was devirequired items for 2 of the confidence in the reviewed with patient 18. The administrator plan of care was devirequired items for 2 of the confidence in the reviewed with patient 18. The administrator plan of care was devirequired items for 2 of the confidence in the reviewed with patient 18. The administrator plan of care was devirequired items for 2 of the confidence in the reviewed with patient 18.	rvices on behalf of the patient or representative will discrimination or reprisal for or 5 of 5 records reviewed.  For failed to ensure the end of the right that the patient end the has the right under Indianal tient's clinical record for 5 of (See S 510)  For failed to ensure patients are home health agency must also are failed to ensure patient or the patient or the patient or the patient's curnishing services on behalf gency and document both complaint and the resolution of 5 records reviewed.  For failed to ensure the adequately met in the home wed with patient harm that to affect all the agency's or failed to ensure the envelopment of 1 record tharm. (See S 522)  For failed to ensure a medical eloped and included all the of 3 clinical records reviewed was provided with a skilled	N 449			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	·
BRIGHTS	TAR OF LAFAYETTE IND	IANA	JTIVE DRIVE SU TE, IN 47905	JITE 2A	
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N 449	Continued From page	e 16	N 449		
	condition or changes patient's condition in reviewed of patients or patient harm. (See S 20. The administrator records included a nupatient records review home health aide only 21. The administrator egistered nurse mad to identify the patients required by agency previewed. (See S 540 22. The administrator egistered nurse estatof 5 clinical records records in the patient could affect the patient could affect the patient could affect the patient could affect the patient clinical records review resulted in patient harms and the patient could affect the patient clinical records review resulted in patient harms and the patient could affect the patient clinical records review resulted in patient harms and the patient could affect the patient clinical records review resulted in patient harms and the patient could affect the patient clinical records review resulted in patient harms and the patient could affect the patient clinical records review resulted in patient harms and the patient could affect the patient co	d of changes in the patient's that could affect the 1 of 1 clinical records whose care resulted in 527)  If failed to ensure the clinical rsing plan of care for 3 of 3 wed of patients receiving y services. (See S 533)  If failed to ensure the e an initial assessment visit is immediate care needs as olicy for 3 of 5 clinical record of the polished a plan of care for 4 eviewed. (See S 542)  If failed to ensure the med the physician of the of patients whose care rem. (See S 546)  If failed to ensure the ed of patients whose care rem. (See S 546)			
	25. The administrato physical therapist con assessment visit with	r failed to ensure the npleted the initial			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		012722	B. WING		02/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
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	OLIMAN DV OT		E, IN 47905	DDOMDEDIO DI ANI OF CODDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 449	N 449 Continued From page 17		N 449		
	referral as required by agency policy in 2 of 2 clinical records reviewed of patients receiving physical therapy only. (See S 562)  26. The administrator failed to ensure a qualified social worker provided services as ordered in 1 of 1 record reviewed with orders for a social worker. (See S 572)  27. The administrator failed to ensure documentation evidenced that, prior to patient contact, home health aides successfully completed a competency evaluation program in 6 of 6 home health aide files reviewed. (See S 598)				
N 458	410 IAC 17-12-1(f) Ho administration/manag		N 458		
	Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:  (1) Receipt of job description.  (2) Qualifications.  (3) A copy of limited criminal history pursuant to IC 16-27-2.  (4) A copy of current license, certification, or registration.  (5) Annual performance evaluations.				
		t as evidenced by: ile and policy review and failed to ensure a limited			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE INI	DIANA	CUTIVE DRIVE SUIT	ΓE 2A		
		LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 458	criminal history or exapplied for within 3 band included a lifetin 10 of 12 employee fithat required a limite D, F, G, H, I, J, K, ar contained document of 12 files reviewed (J, K, and L), and dosocial worker was que worker file reviewed. The findings include:  1. Personnel file A, patient contact 1/14/evidence the employ social worker and was file contained a crimi 11/15/11. It is unknowent so it was unable check was a lifetime.  410 IAC 19-9-28 stated, "means a perdegree from a school the Council on Social 2. Personnel file B, evidence orientation administrator and alt.  3. Personnel file C, patient contact 12/8/evidenced the patier (Montague, Texas) of Intellicorp criminal hi 6/13/11 only went batexas, and does not	cpanded criminal history was business days of employment the criminal history check for les reviewed of employees and criminal history (Files A, C, and L), employee files ation of job orientation for 12 (files A, B, C, D, E, F, G, H, I, cumentation evidenced the utilities of 1 of 1 social (file A).  It date of hire 11/1/11 and first 12 with patient # 4, failed to be met the qualifications of a final history by Intellicorp on the social work are to be determined if the check of the	N 458			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE INI	DIANA 25 EXE	ADDRESS, CITY, STATE CUTIVE DRIVE SUITE ETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 458	states. It is unknown went so it was unable check was a lifetime evidence orientation practical nurse.  4. Personnel file D, patient contact 12/23 evidenced an Intellic was obtained on 4/25 years. The file failed the job as a registered to the job as a registered.  5. Personnel file E, evidence orientation nursing and administration of the patient contact 12/8/evidenced an Intellic was obtained on 9/2 the check was a lifet evidence orientation nurse.	does not identify which how far back the check to be determined if the check. The file failed to to the job as a licensed date of hire 4/13/11 and first 8/11 with patient # 4, orp criminal history check 8/11 that only went back 10 to evidence orientation to ed nurse.  date of hire 4/7/11, failed to to the job as the director of trator.  date of hire 9/15/11 and first 11 with patient # 4, orp criminal history check 1/11, but does not indicate time check. The file failed to to the job as a registered date of hire 6/3/11 and first	N 458			
	evidenced an Intellic was obtained on 6/1- search" does not ind checked or if the sea	orp criminal history check 4/11. The "Multistate criminal icate which states were arch was a lifetime check lence orientation to the job as				
	8. Personnel file H, patient contact 12/13 evidenced an Intellic check was obtained	date of hire 5/18/11 and first 8/11 with patient # 4, orp national criminal history on 5/20/11 but did not was a lifetime check. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPL	
A. BUILDING:	
012722 B. WING 021'	17/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 458 Continued From page 20 file failed to evidence orientation to the job as a home health aide.  9. Personnel file I, date of hire 10/10/11 and first patient contact 12/11/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 10/12/11 for Tippecanoe and Marian counties in Indiana. As an adult the employee has lived in White, Tippecanoe, Lake, and Marion counties. The document did not indicate if the search was a lifetime check. The file failed to evidence orientation to the job as a home health aide.  10. Personnel file J, date of hire 11/1/11 and first patient contact 12/24/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 11/3/11 for Lake County Illinois and Tippecanoe County Indiana. The search failed to evidence the years searched and it was unable to be determined if it was a lifetime check. The file failed to evidence orientation to the job as a home health aide.  11. Personnel file K, date of hire 6/22/11 and first patient contact 12/8/11 with patient # 4, evidenced an Intellicorp criminal history check was obtained on 6/23/11 for a "Multistate Criminal Search" and Tippecanoe County Indiana. The search and the file failed to evidence orientation to the job as a home health aide.  12. Personnel file L, date of hire 1/2/28/11 and first patient contact 12/3/11/11, evidenced an Intellicorp criminal history check was obtained on 1/4/12 for Tippecanoe, Pulaski, and White counties. The search failed to evidence of it was a lifetime check. The file failed to evidence it was a lifetime check.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE INI	DIANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 458	Continued From pag	e 21	N 458			
N 462	Personnel File" state provide direct patient following at a minimul history documentar job."  14. On 2/15/12 at 1: indicated she did not contract with Intellict check the Indiana Renational search when submitted.  15. On 2/16/12 at 4: indicated the personar a previous home heat agency did not condusearches when the alicense dated 12/8/12 patients.  410 IAC 17-12-1(h) Hadministration/management contact examination by a phyno more than one hubefore the date that the patient contact. The be of sufficient scope employee will not spirit	trealize until 2/15/12 that the orp did not automatically epository or complete a in the request for search was as 5 PM, employee N nel files reviewed were from alth agency license and the files reviewed their new agency received their new and began to admit.  Home health agency gement ach employee who will have a shall have a physical ysician or nurse practitioner andred eighty (180) days the employee has direct physical examination shall act oensure that the read infectious or	N 462			
	This RULE is not me Based on personnel					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED	
		012722	B. WING	<del> </del>	02	2/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE INC	DIANA 25 EXEC	DDRESS, CITY, STATE UTIVE DRIVE SUITE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 462	of first patient contact was free from commit files reviewed (A, B, I with the potential to a patients.  Findings include:  1. Personnel file A, opatient contact 1/14/revidence a physical of 180 days of the first patient care in director of nursing was not about direct patient care in director of nursing was not about a completed. The of nursing was not about direct patient care in director of nursing was not about a contact 12/23 evidence a physical of 180 days of the first patient contact 12/15/11 with evidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days of the first patient contact 12/8/revidence a physical of 180 days o	rafiled to ensure all visical exam within 180 days at that identified the employee unicable disease for 11 of 12 D, E, F, G, H, I, J, K, and L) affect all the agency's date of hire 11/1/11 and first 12 with patient # 4, failed to exam was completed within patient contact.  It also of hire 4/28/11, the nursing and alternate of evidence a physical exam arefore, the alternate director olle to perform or monitoring the event the administrator / as incapacitated.  It with patient # 4, failed to exam was completed within patient contact.  It also of hire 4/7/11, the idministrator and first patient and patient # 4, failed to exam was completed within patient # 4, failed to exam was completed within patient contact.  It with patient # 4, failed to exam was completed within patient contact.	N 462			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU FE, IN 47905	JITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
N 462	evidence a physical ed 180 days of the first physical exam was ed the first patient contact 12 physical exam was ed the first patient contact 13. The undated polithealth Screening state and contract personner of baseline health screamination will be personner to patients A examination will be presented to patients	ate of hire 5/18/11 and first atient contact.  ate of hire 5/18/11 and first atient contact.  ate of hire 5/18/11 and first atient contact.  ate of hire 10/10/11 and first atient contact.  ate of hire 10/10/11 and first atient contact.  ate of hire 11/1/11 and first atient contact.  ate of hire 11/1/11 and first atient contact.  ate of hire 6/22/11 and first atient contact.  ate of hire 6/22/11 and first atient contact.  date of hire 6/22/11 and first atient contact.  date of hire 12/28/11 and atient contact.	N 462		
	14. On 2/16/12 at 4:3	35 PM, employee N			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		012722	B. WING	<del></del>	02	2/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND		CUTIVE DRIVE SUIT	E 2A		
BIGGITTO	TAIL OF LAFATETTE IND	LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 462	Continued From page	e 24	N 462			
	indicated there were available for the person					
N 464	410 IAC 17-12-1(i) Ho administration/manag	<del>-</del> -	N 464			
	ensure that all employersons providing call and contractors having evaluated for tubercul follows:  (1) Any person with a tuberculosis or a negulosed baseline two-step tube Mantoux method or a unless the individual tuberculin skin test had during the previous two result was negative.  (2) The second step test using the Mantou administered one (1) first tuberculin skin tee (3) Any person with:  (A) a documented:  (i) history of tuberculing in previously positive or  (iii) completion of treat (B) newly positive restest;  must have one (1) childingnosis of tuberculosis.	re on behalf of the agency, ag direct patient contact are losis and documentation as a negative history of ative test result must have a perculin skin test using the quantiferon-TB assay has documentation that a as been applied at any time welve (12) months and the of a two-step tuberculin skin ax method must be to three (3) weeks after the st was administered.  Osis; test result for tuberculosis; or sults to the tuberculin skin est rediograph to exclude a				
		nually; and mum, a tuberculin skin test ethod or a quantiferon-TB				

Indiana State Department of Health

Indiana State Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE IND	DIANA 25 EXE	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT ETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 464	Continued From page 25  assay unless the individual was subject to subdivision (3).  (5) Any person having a positive finding on a tuberculosis evaluation may not:  (A) work in the home health agency; or  (B) provide direct patient contact; unless approved by a physician to work.  (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:  (A) working for the home health agency; or  (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.		N 464			
	interview, the agency Tuberculosis (TB) so Mantoux was comple employee did not hav within the previous to report was included fo of 12 files reviewed (	file and policy review and				
	patient contact 1/14/r evidence a two step completed at hire or documentation of a n screening completed months or a chest x n	within the previous twelve ray report.				
	2. Personnel file B, o	date of hire 4/28/11, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE IND	IANA 25 EXEC	ADDRESS, CITY, STATI CUTIVE DRIVE SUI CTTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 464	tuberculosis screenin that the employee had negative tuberculosis the previous twelve in report.  3. Personnel file D, comparished a two steps to completed at hire or the documentation of an screening completed months or a chest x in the documentation of an screening completed at hire or the documentation of an screening completed at hire or the documentation of an screening completed months or a chest x in the documentation of an screening completed at hire or the documentation of an screening completed at hire or the documentation of an screening completed months or a chest x in the documentation of an screening completed months or a chest x in the documentation of an screening completed months or a chest x in the documentation of a necessity of the documentation of a neces	ursing and alternate of evidence a two steps grades completed at hire or documentation of a screening completed within months or a chest x ray.  Itate of hire 4/13/11 and first first first with patient # 4, failed to suberculosis screening was that the employee had egative tuberculosis within the previous twelve ay report.  Itate of hire 6/3/11 and first fir	N 464			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING: _		COMPL	ETED
		012722		B. WING		02/1	7/2012
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDR	ESS, CITY, STAT	TE. ZIP CODE		
				VE DRIVE SU			
BRIGHTS	TAR OF LAFAYETTE IND	DIANA		, IN 47905			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	DECLUATION OF LOCARENTIES (INC. INCORNATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETE DATE
N 464	Continued From page 27			N 464			
IN 404	7. Personnel file K, dipatient contact 12/8/1 evidence a two step to completed at hire or to documentation of a nescreening completed months or a chest x results.  8. Personnel file L, dipatient contact 12/31/3 step tuberculosis screening or that the emploint negative tuberculosis the previous twelve more port.  9. The undated policity Health Screening state Any employee, staff in personnel who provide agency through direct be evaluated for tube negative history of t	late of hire 6/22/11 and first 11 with patient # 4, failed to suberculosis screening was that the employee had egative tuberculosis within the previous twelve ay report.  Late of hire 12/28/11 and first 11, failed to evidence a two eening was completed at evening was completed within the previous twelve ay report.  Late of hire 12/28/11 and first 11, failed to evidence a two eening was completed at evening was completed within the providence of the screening completed within the providence of the two entracts are contract the care on behalf of the troulosis. Any person with a characteristic care contact must be reculosis or a negative test and to the providence of the two-step tuberculin antoux method or a care tuberculin skin test has tuberculin skin test has time during the previous the result was negative. If	st o a n	N 404			
		fter the first tuberculin test					
	10. On 2/16/12 at 4:3 indicated there were available for the person	no more documents					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17	7/2012
	ROVIDER OR SUPPLIER	25 EXECU	DRESS, CITY, STA			
		LAFAYET	TE, IN 47905			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
N 466	Continued From page	e 28	N 466			
N 466	410 IAC 17-12-1(j) Home health agency administration/management		N 466			
	Rule 12 Sec. 1(j) The the:	e information obtained from				
	(h); and	tions required by subsection				
	<ul><li>(2) tuberculosis evalu follow-ups required by</li></ul>					
		n separate medical files and al medical records, except as n (k).				
	failed to ensure the co	n and interview, the agency onfidential medical records eated as confidential for 12 G, H, I, J, K, and L) of 12				
	The findings include:					
	personnel files for rev B, C, D, E, F, G, H, I, stored in separate fol- information was obse individual and separa same drawer that hou personnel information health files were iden- file jacket color and the	rved to be housed in te folders side by side in the used all of the other n. Employee N indicated the tified as a health file by the ne other personnel file in color and they were all				
N 478	410 IAC 17-12-2(d) C improvement	A and performance	N 478			
	Rule 12 Sec. 2(d) If r	personnel under contracts				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		012722	B. WING	B. WING		
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	2/17/2012
BRIGHTS	TAR OF LAFAYETTE INC	DIANA 25 EXEC	UTIVE DRIVE SUIT	E 2A		
	TAK OF EAFAIETTE INC	LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 478	are used by the home be a written contract and the home health following:  (1) That patients are the primary home he.  (2) The services to look (3) The necessity to home health agency qualifications.  (4) The responsibility developing plans of (5) The manner in word controlled, coordinate primary home health (6) The procedures scheduling of visits, a patient evaluation.  (7) The procedures	e health agency, there shall between those personnel agency that specifies the e accepted for care only by alth agency. The furnished of conform to all applicable policies including personnel by for participating in care. Which services will be ed, and evaluated by the agency. For submitting clinical notes, and conducting periodic	N 478			
	contracts included all contracted therapy properties.  1. The administrator indicated on 2/15/12 only contracted therative 2. The contract titled Agreement" dated Au Therapy, Etc. and the and specify 1) The the care only by the prime	et as evidenced by: gency contract and railed to ensure written the required items for 1 of 1 rovider.  / director of nursing at 11:08 AM the agency had				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		012722	B. WING		02	/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE INI	DIANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT ETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
N 478	qualifications; 3) The participating in devel manner in which service coordinated, and evaluated health agency; 5) The clinical notes, schedule periodic patient evaluated procedures for paymunder the contract.  3. On 2/17/12 at 1 Pedirector of nursing in that all of the requires	es including personnel responsibility for oping plans of care; 4) The vices will be controlled, aluated by the primary home e procedures for submitting uling of visits, and conducting	N 478			
N 482	services from another agency, organization the personnel record office of the employer the home health age notice.  This RULE is not me Based on interview a and policy, the agency contracted providers available personnel frontracted physical the Findings include:  1. On 2/16/12 at 10:	nen contracting temporary er licensed home health , or independent contractor, s shall be maintained at the er and shall be available to ncy upon two (2) hours	N 482			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		012722	B. WING		02/17/2012	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA 25 EXECU	TIVE DRIVE SU	JITE 2A		
		LAFAYETT	E, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
N 482	with patient # 4, failed	nt contact was on 12/20/11 I to evidence a limited xpanded criminal history	N 482			
	was completed by the Therapy Etc The file physical examination patient contact and arexposure to tuberculor tuberculosis skin test however, the docume skin test was read and 2. On 2/16/12 at 11:2 the owner of the contract able to produce a 9 PM on 2/16/12 via for The contractor only relicense from the thera	e contracted therapy e also failed to evidence a within 180 days prior to nual monitoring for sis. The file evidenced one was placed on 8/29/11; ant failed to evidence the d the results were negative.  O AM, employee E indicated racted therapy company was complete personnel file until ax or in person on 2/17/12.				
	Health Screening" start Any employee, staff in personnel who provid agency through direct be evaluated for tube negative history of tube result must have a baskin test using the Maquantiferon - TB assart documentation that a been applied at any tit twelve months and the individual does not evidence of a negative the past twelve month be given at the time of	e care on behalf of the transport patient care contact must reculosis. Any person with a perculosis or a negative test seline two-step tuberculin antoux method or a y unless the individual has tuberculin skin test has me during the previous e result was negative. If				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		012722	B. WING		02	/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE IND	DIANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 482	"Independent Contract BrightStar and the contract Therapy Etc." failed to would provide BrightStar	d August 19, 2011, titled ctor Agreement" between intracted therapy company o evidence Therapy Etc. Star with a current complete 2 hours of the request.	N 482			
N 488	410 IAC 17-12-2(i) ar improvement  Rule 12 Sec. 2(i) A hadevelop and impleme of discharge of service legal representative, responsible for the parallel calendar days before  (j) The five (5) day provided in the service services.  (3) The patient refusive services and the services are considered in the services.	and (j) Q A and performance  some health agency must ent a policy requiring a notice te to the patient, the patient's for other individual atient's care at least five (5) the services are stopped.  The services are stopped.  The does not apply in the tees: The semployees would be at the cant risk if the home health provide services to the  The services to the The services to the The services to the The services to the The services to the The services to the The services to the The services to the The services to the The services to the The services to the the services to the The services to the the services to the services the services to the the services the s	N 488			
	regulatory criteria, su order, and the home	nger meets applicable ch as lack of physician's health agency informs the resources to assist the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
N 488	Continued From page 33		N 488			
	the agency developed requiring a 5 day notice agency.	t as evidenced by: ne agency failed to ensure d and implemented a policy ce of discharge for 1 of 1				
	Findings include:					
	On 2/17/12 at 2:05 PM, employees E and N indicated the agency did not develop a policy requiring a notice of patient discharge at least five (5) days before services are stopped.					
N 496	410 IAC 17-12-3(b) P	atient Rights	N 496			
	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:  (1) The patient's family or legal representative may exercise the patient's rights as permitted by law.					
	interview, the agency the patient's right that representative may ex	ts document review and failed to inform patients of				
	The findings include:					
	and Responsibilities" patient right that the p	nent titled "Patient's Rights failed to evidence the patient's family or legal exercise the patient's rights				
	2. Clinical records #1	-5 evidenced the patients				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	·	
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
N 496	document included a reviewed and receive of admission and including and receive of admission and including and responsibilities, Section and receive of admission and receive of admission and receive of admission and receive of admission. She indicate the documents titled "Patt Responsibilities, Section and receive of admission. She indicate of the documents titled and receive of a review of the documents titled and receive of a review of the documents titled and receive of the documents titled and receive of the documents of the documents titled and receive of the documents of	nent titled "Admission dgement Statement." The list of items that were d by the patient at the time uded on the list was "Client sponsibilities." The agency ocument titled "Client Bill of coilities."  5 PM, employee N indicated that document was placed in er. She indicated the ent was updated and should then identified as policy # Of Rights" and there was no ottents were informed of this me of admission or following ated this specific right was agency's three patient rights	N 496			
N 500	his or her rights as a agency as follows: (2) The patient has (B) Voice grievances care that is (or fails to the lack of respect for furnishing services or agency and must not discrimination or reprint This RULE is not me Based on the patient	ent has the right to exercise patient of the home health the right to the following: s regarding treatment or be) furnished, or regarding property by anyone who is behalf of the home health be subjected to isal for doing so.	N 500			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,			A. BUILDING: _			
		012722	B. WING		02/17/2012	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS'	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU	JITE 2A		
		LAFAYETT	E, IN 47905		,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
N 500	Continued From page	e 35	N 500			
	their right to voice grid that is or failed to be a property by anyone p of the agency and the will not be subjected for grievances voiced reviewed.	evances regarding treatment furnished, lack of respect for roviding services on behalf e patient or representative to discrimination or reprisal for 5 (#'s 1-5) of 5 records				
	The findings include:					
	1. The agency document titled "Patient's Rights and Responsibilities" failed to evidence the patient right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so.					
	had signed the docum Packet and Acknowle document included a reviewed and receive of admission and incl Bill of Rights and Res	dgement Statement." The list of items that were d by the patient at the time uded on the list was "Client sponsibilities." The agency ocument titled "Client Bill of				
	the wrong Patient Rig the patient home fold Patient Right docume have been the docum 02.06 and titled "Bill of documentation the pa specific right at the tir admission. She indice	5 PM, employee N indicated plot document was placed in er. She indicated the ent was updated and should ment identified as policy # Of Rights" and there was no attents were informed of this me of admission or following atted this specific right was agency's three patient rights				

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE	
BRIGHTS	TAR OF LAFAYETTE IND	IANA	UTIVE DRIVE SU ITE, IN 47905	ITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 500	Continued From page	e 36	N 500		
		tient's Rights and tion 02.06 - Bill of Rights, ) - Bill of Rights Form."			
N 510	410 IAC 17-12-3(b)(3	) Patient Rights	N 510		
	her rights as a patient as follows:  (3) The patient or patheast the right under Inpatient's clinical reconexceptions apply. The advise the patient or representative of its paregarding the access.  This RULE is not measured by the right that the patient of the patient right under Interview, the right under Interview.	te home health agency shall the patient's legal policies and procedures ibility of clinical records.			
	The findings include:				
	and Responsibilities" patient right that the p	ment titled "Patient's Rights failed to evidence the patient or their representative idiana law to access the rd.			
	had signed the docur Packet and Acknowle document included a	1-5 evidenced the patients ment titled "Admission edgement Statement." The list of items that were			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IN	DIANA	CUTIVE DRIVE SUIT TTE, IN 47905	E 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
N 510	Bill of Rights and Refailed to evidence at Rights and Respons  3. On 2/17/12 at 1:4 the wrong Patient Right documnave been the documnave been the documnave been the documnation the properities of the patient Right at the tradmission. She indinot on any of the the documents titled "Par Responsibilities, Secondary Rights and Responsibilities and	cluded on the list was "Client sponsibilities." The agency document titled "Client Bill of ibilities."  5 PM, employee N indicated ght document was placed in der. She indicated the ent was updated and should ment identified as policy # Of Rights" and there was no atients were informed of this ime of admission or following cated this specific right was a agency's three patient rights	N 510			
N 514	following: (1) Investigate con the patient's family or regarding either of th (A) Treatment or ca furnished. (B) The lack of res by anyone furnishing home health agency (2) Document both complaint and the re  This RULE is not me Based on patient rig interview, the agency	th agency shall do the applaints made by a patient or or legal representative are following: are that is (or fails to be)  pect for the patient's property g services on behalf of the the existence of the solution of the complaint.	N 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
BRIGHTS	TAR OF LAFAYETTE IN	DIANA	TTE, IN 47905	IE ZA		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 514	complaints made by family or legal represor care that is or fails lack of respect for the anyone furnishing see health agency and of the complaint and complaint for 5 (#'s'). The findings include  1. The agency document and Responsibilities patient right that the investigate complaint patient's family or lest treatment or care that the lack of respect for anyone furnishing see health agency, and existence of the complaint.  2. Clinical records # had signed the document included a reviewed and receiv of admission and ince Bill of Rights and Refailed to evidence a Rights and Response.  3. On 2/17/12 at 1:4 the wrong Patient Right document included a reviewed and receiv of admission and ince Bill of Rights and Response.  3. On 2/17/12 at 1:4 the wrong Patient Right document included a Rights and Response.  3. On 2/17/12 at 1:4 the wrong Patient Right document Right R	the patient, or patient's sentative, regarding treatment is to be furnished and/or the re patient's property by ervices on behalf of the home locument both the existence of the resolution of the falso of 5 records reviewed.  It is ment titled "Patient's Rights of a patient or the gal representative regarding at is (or fails to be) furnished, or the patient's property by ervices on behalf of the home will document both the aplaint and the resolution of the statement." The a list of items that were ed by the patient at the time cluded on the list was "Client esponsibilities." The agency document titled "Client Bill of	N 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER	DIANA 25 EXEC	DDRESS, CITY, STATE UTIVE DRIVE SUIT TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 514	specific right at the ti admission. She indi- not on any of the the documents titled "Pa Responsibilities, Sec	me of admission or following cated this specific right was agency's three patient rights	N 514			
N 520	Rule 13 Sec. 1(a) Patient Care  Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.  This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure appropriate staff were available to meet the patient's needs in the home in 1 of 1 record reviewed with patient harm resulting in the potential to affect all the agency's patients. (#4)		N 520			
	titled "Initial Phone C FORM" which indica the agency on Octob the patient was recei extended care facility Documentation state hemiparesis on right but can dress self, get down, get up, because family leave	y at the time of the call. d, "Had a stoke in May, has side, can move and standup need someone every day need someone full time,				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			201251110.			
		012722	B. WING		02/17/2012	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BDICHTS.	TAR OF LAFAYETTE IND	JANA 25 EXECU	JTIVE DRIVE SU	JITE 2A		
BRIGITIS	IAR OF EAFAILTIE IND	LAFAYET	TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
N 520	Continued From page	e 40	N 520			
N 920	12/8/11 at 5 PM, comstates, "Indwelling caside weakness, use of board, psycho / neuroplace, forgetful, in ulcers Describe Skin. [centimeter] unstages slough." The docume "Functional Screen" in indicate the patient's patient's ability or assa a list of daily living tasindicated by placing at that the patient was obathing / showering, of toileting, preparing melephone. The asse fashion that the patient set up," assistance we care, shaving, bed meeting. The assessor documented "Function BrightStar would provishowering, dressing, The assessment indicting incontinent of stool. The physician was not identified, or an order by the nurse. The assessment indicting the patients needs as the patients needs as	pleted by employee F, which theter, hemiparesis, right of assistive device slide plogic alert, oriented person, tegumentary pressure Abnormalities: 2 cm able 100 % covered with ent included an area titled in which the assessor was to level of function, the sistance level identified with esks / activity. The assessor a check mark in the column dependent on others for dressing / undressing, eals, eating, and use of ssor indicated in same int required "human help - ith transfers, hair care, oral obility, medications, and in assessed and in al Screen" and indicated vide assistance with bathing, undressing, and toileting. Cated the patient was The record failed to evidence tified of the wound, once if for treatment was obtained sessment failed to identify or caregivers, the tasks they their level of skill in caring for	N 320			
	Plan of Care" dated 1 assigned, indicated w services that were as	2/8/11 with the discipline vith an X, to be aide. The signed to be performed by				
		e - bed - partial / complete as needed, mouth care daily,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
NAME OF D				TE 710 CODE	02/17/2012
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA FIVE DRIVE SU		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	E, IN 47905		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 520	Continued From page	e 41	N 520		
	Continued From page 41 shave electric as needed, skin care daily, dressing daily, catheter care daily, assist with feeding, and turning and repositioning every 2 hours.  C. The record evidenced employee H, a home health aide, provided services on 12/13/11				
	nome health aide, provided services on 12/13/11 and documented "12/13/11 - I noticed while (5:30 p) changing [patient name] brief that sore on [patient] bottom / coccyx looked red, blue / black. [patient] told me it had been there awhile. I notified [name of director of nursing] by phone at 6 PM."				
	prescription via facsin attending physician a stated, "Daily nurse v	videnced receipt of a nile on 12/15/11 from the lso dated 12/15/11 which isits. Daily Foley flush. Eval for PT [physical therapy] / rapy] / Speech."			
	"Physician Orders" da employee E which sta Dr. [name] office, spo Informed we had rece care but needed clarit daily nurse visits with [name] a plan of care plans for skilled nursit visit weekly for wound education, and for Fo education provided to [home health aides] for [name] stated she did to this order and would to MD. Asked [name] very larger than the state of t	eived the orders for skilled fication on orders regarding daily Foley flush. Informed would be created but that ng visits would be set for 1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 12.11 .		.52	A. BUILDING: _		"" "	
		012722	B. WING		02/1	7/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	IVE DRIVE SU	JITE 2A		
	CLIMMADY CT		E, IN 47905	DDOWNERIC PLAN OF CORRECTION	\ <u>\</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
N 520	Continued From page	e 42	N 520			,
	from 5 PM through 6: employee F, which st area cleansed Tegade caregiver on wound or relieved methods to in Attached to the skilled another document title Sheet" which stated, Coccyx, type X pro 12/15/11 stage / grad 0.3 cm / 2 cm X 2 cm undermining N Tunne periwound (surrou Red non blanching trough one wound on 12 failed to evidence an the time of the visit.	ated, "Wound Care: Coccyx erm applied. Instructed are Reinforced pressure mprove skin integrity." d nurse visit note was ed "Wound Care Flow "Wound Location Left essure assessment date e 2 LXWXD in CM 0.2 X in surrounding red area eling N odor 0 % Red 100% inding skin) describe - Deep eatment / protocol is note indicated there was 2/15/11. The clinical record order for the Tegaderm at				
	failed to evidence an order for the Tegaderm at					

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indiana S	state Department of He	aith				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		012722	B. WING		02/1	7/2012
					1 02/1	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	UTIVE DRIVE SI	JITE 2A		
	-	LAFAYET	TE, IN 47905			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
N E20	0	- 40	N 520			
N 520	Continued From page	e 43	N 520			
	H. The record e	videnced a document titled				
	"Home Health Certific	cation and Plan of				
	Treatment" with start	of care 12/15/11 through				
	02/12/12, Principle D	iagnosis Right flaccid				
	hemiparesis, addition	diagnosis, CVA aftercare,				
	and included orders f	or "SN [skilled nurse] 1 wk				
	[week] 3, 0 [zero] wk	[week] 5, 1 wk [week] 1,				
		le] 2 X [times] daily - 3 hr				
		- total = 5 hrs / daily. PT -				
		val and treat, ST [speech				
		eat, MSW [medical social				
	-	sist Skilled Nursing				
		Foley catheter daily with 3 cc				
		e]. 3. Patient to flush				
		f trained HHA and education				
	provided on proper flu	- ·				
	, ,	wound. Change 3 times				
		needed]. Trained HHA may				
	1	d cleanser Home				
		May reapply Tegaderm to				
		encied and under nursing				
	•	ed Nursing Goals: 2.				
		alth aides will be able to				
		roper catheter flushing				
	-	veek. 3. Patient's wound will				
	·	ations by end of certification				
	•	Administration Medical Clinic				
	to draw PT / INR [F					
		zed Ratio] and send results nary care physician]. Next				
		January 3, 2012 at 0940."				
		tion List was attached to the				
	plan of care and indic					
		illigrams daily. The plan of				
		cover sheet facsimile dated				
		ted, "[name] There are 9				
		Please have Dr. [name]				
		nd date the 2nd page."				
		vidence the patient was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER	DIANA 25 EXEC	DDRESS, CITY, STATE UTIVE DRIVE SUIT			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 520	in the ordered cathe flushes the patient windependently and windepende	constrated ability to participate ter flushes, which steps of the vas capable of completing which tasks the patient was to rom the aides. The record ere was participation of any mily, volunteer, or other hired in BrightStar, that was complete the wound care and in or for the patient.  Videnced a document titled Notes" signature of 12/21/11, that stated, 10 P flushed [name] centimeter]."  Evidenced a document titled Notes" signature of 12/23/11, that stated, [name of employee E] assure wounds, appearance & evidenced a document titled Notes" signature of 2/24/11, that stated, "Flushed NS [normal saline] to L [left] heel."  Evidenced a document titled Notes" signature of 2/25/11, that stated, "Noted catheter] coming from urethra, of nursing] at 5:56 PM. Told to check tomorrow."	N 520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012
			DE00 0174 074	TE 710 0005	1 02/1//2012
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA TIVE DRIVE SU		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	E, IN 47905	JITE ZA	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
N 520	"Cath [catheter] clean 12/29/11 cath [cath solution Coccyx applied Tegaderm to long 12/29/11 5 F feet L [left] ankle blist to [director of nursing blister 12/30/11 centimeter no swelling cath [catheter] car additional note was w Late entry. T.C. [telep at Foley site. States resolved." The note with the stated, "Increas daily to 30 CC [cubic saline]." The documdirector of nursing.  O. The record en "Weekly CNA / HHA Nemployee H, that state [patient's name] Tega Tegaderm according nursing] instructions. noticed a blister on [phe / she said it was phe 2.5 cm L: 2 cm. Calle 9:45 a to report it. [nainstructed me to put at I did."  P. The record experience of the record expense of the potential of the put at I did."	ed 12/26/11 that stated, led, drained, flushed heter] flush 30 cc saline Tegaderm intact and clean. L [left] ankle blister 2 cm PM Bilateral swelling of er 2.5 cm in diameter, spoke I told about changes in L [left] ankle 2.5 g, covered with Tegaderm. e and flush." The an written and stated, "12/26/11 shone call] regarding blood no active bleeding. Has was signed by employee E.  Videnced a document titled rder Form" dated 12/23/11 se Foley cath [catheter] flush centimeter] .9% NS [normal ent was signed by the	N 520		
	date of birth with state	ed, "Taken 12/28/11 at 10 CNA / HHA W [width] 2.5			

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A. BUILDING:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING: _			
012722 B. WING 02/17/2012			012722	B. WING		02/1	7/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PR	VIDER OR SUPPLIER	OVIDER OR SUPPLIER STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905	BRIGHTST	R OF LAFAYETTE IND	AR OF LAFAYETTE INDIANA		JITE 2A		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETE DATE
Continued From page 46  cm L [length] 2.0 cm. Fluid filled. Able to blanch the skin surrounding bilster. No active drainage noted. Request orders sent to Dr. [attending physician] to apply Tegaderm and allow trained HHA's to apply and report any changes to nursing supervisor." The narrative was signed by the director of nursing and dated 12/28/11.  Q. The record evidenced a document titled "Physician Orders" dated 12/28/11 requesting an order and stated, "Request Order to apply Tegaderm to fluid filled bilster to L [left] heel measuring 2.5 cm W 2.0 cm L. Able to blanch surrounding tissue. Bilster intact. No active drainage noted. HHA's may be trained to apply Tegaderm noted propt any changes to nursing supervisor" signed by the director of nursing. The document indicated the facsimile was sent to the attending physician at 12:20 PM on 12/28/11. The order was signed by the attending physician and dated 12/28/11. The order was noted as received by the director of nursing (DON) and dated 12/28/11. The record failed to evidence a skilled nurse assessed the patient and the wounds.  R. The record evidenced document titled "Weekly CNA / HHA Notes" signature of employee H and stated, "12/27/11 6 P I flushed [patient's name] with 30 cc (cubic centimeter) as [name of DON] instructions while getting [patient's name] pain. [patient] saked for medication sol gave him 1 hydrocodone. I notified [DON] at the end of the shift. 12/28/11 6:30 P I flushed [patient] at the end of the shift. 12/28/11 6:30 P I flushed [patient] catheter with 30 cc as instructed by [DON]. [patient] Tegaderm on [his / her] bottom and foot were still intact."  S. The record evidenced a document titled		cm L [length] 2.0 cm. he skin surrounding to hoted. Request order onlysician] to apply Ted HA's to apply and resupervisor." The narr director of nursing and Q. The record expression orders day order and stated, "Refegaderm to fluid filler measuring 2.5 cm W. surrounding tissue. Be drainage noted. HHA regaderm and report supervisor" signed by document indicated the attending physician at The order was signed and dated 12/28/11. The skilled nurse assesse wounds.  R. The record expression of DON] instruction of DON] instruction of DON] instruction of DON] at the control of the patient of DON] at the control of DON] at the control of the patient of DON] at the control of DON]. The patient of DON] instruction of DON] at the control of the patient o	cm L [length] 2.0 cm. Fluid filled. Able to blanch the skin surrounding blister. No active drainage noted. Request orders sent to Dr. [attending physician] to apply Tegaderm and allow trained HHA's to apply and report any changes to nursing supervisor." The narrative was signed by the director of nursing and dated 12/28/11.  Q. The record evidenced a document titled "Physician Orders" dated 12/28/11 requesting an order and stated, "Request Order to apply Tegaderm to fluid filled blister to L [left] heel measuring 2.5 cm W 2.0 cm L. Able to blanch surrounding tissue. Blister intact. No active drainage noted. HHA's may be trained to apply Tegaderm and report any changes to nursing supervisor" signed by the director of nursing. The document indicated the facsimile was sent to the attending physician at 12:20 PM on 12/28/11. The order was signed by the attending physician and dated 12/28/11. The order was noted as received by the director of nursing (DON) and dated 12/29/11. The record failed to evidence a skilled nurse assessed the patient and the wounds.  R. The record evidenced document titled "Weekly CNA / HHA Notes" signature of employee H and stated, "12/27/11 6 P I flushed [patient's name] with 30 cc [cubic centimeter] as [name of DON] instructions While getting [patient] ready for bed, right side was causing [patient] ready for bed, right side was causing [patient] a lot of pain. [patient] asked for medication so I gave him 1 hydrocodone. I notified [DON] at the end of the shift. 12/28/11 6:30 P I flushed [patient] catheter with 30 cc as instructed by [DON]. [patient] Tegaderm on [his / her] bottom and foot were still intact."	N 520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		012722	B. WING	<del> </del>	02	2/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE IND	IANA 25 EXEC	DDRESS, CITY, STATE UTIVE DRIVE SUIT TTE, IN 47905	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 520	that documented employers visit between 1 included three docume Flow Sheet."  i.) Document Location Coccyx midiassessment date 12/wound in size:0.5 X undermining N [none % Red 100% periwound (surroundiblanchable treatment O [water] Dressing  ii.) Docume Location right coccyx assessment date 12/LXWXD [length, width	gress Notes" dated 12/30/11 bloyee F completed the PM through 1:45 PM and nents titled "Wound Care  Int #1 stated, "Wound line, type X pressure, 30/11 stage / grade 2 0.5 cm exudate none Interpolation N Ing skin) describe Red / protocol cleanse soap H 2 Tegaderm."  Int #2 stated, "Wound Interpolated the type X pressure, 30/11 stage / grade II In, depth]: 2.5 X 1.5	N 520	DEFICIENCY)		
	granulation N peri describe Red blancha cleanse H 2 O / soap Given Pressure relief discussed use of hee does not want to use [unknown]. Verbalize Understanding."  iii.) Docume Location left ankle lat assessment date 12/intact, LXWXD [le 2.5 exudate flu undermining N [no] T granulation N skin) describe intact,	r none % Red 100% wound [surrounding skin] able, treatment / protocol cover Tegaderm. Instruction bony prominence's, I protectors, patient states at this time if area will ad Understanding Partial ent # 3 stated, "Wound eral, type [not indicated] 30/11, stage / grade blister ength, width, depth]: 2.5 X uid filled not draining, unneling N [no] odor none periwound (surrounding				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		012722	B. WING		02/1	7/2012
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTST	AR OF LAFAYETTE IND	IANA	TIVE DRIVE SU TE, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETE DATE
	T. The record ev "Weekly CNA / HHA Nemployee L, dated 12 "Called [DON] becaus swollen and urine was additional narrative wand stated, "12/26/11 [employee L] was infourine assessment. Insclean penis Also in catheter net week. [eunderstanding." The Isigned and dated the "1/3/12."  U. The record ev "Weekly CNA / HHA Nemployee L, dated 12 "Changed Tegaderm isn't as swollen this as me what I needed to co. "Nursing Clinical Prog 5:30 AM and indicated necessary) visit, signed document states, "T. Catheter not draining Changed Foley insobtained yellow cloud sediment. Patient state catheter change."  W. The record ev "Weekly CNA / HHA New Patient state catheter change."	idenced a document titled lotes" signature of lotal lotes lotes and thick." An lotal lotes lot	N 520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/1	7/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
N 520	"Weekly CNA / HHA Nemployee H, dated 1/a changed [patient] Ther] bottom and left for was complaining of sc [patient] said [patient needed to have a bovinformed nurse [DON him 2 laxative pills aff a Dr appointment, so am."  Y. The record ex "Weekly CNA / HHA Nemployee H, dated w "1/3/12 6 P [patient] soil bottom. I flushed [paras instructed by [DON [patient] Tegaderm or [patient] using 30 cc [instructed by [DON] left foot."  Z. The record ex "Weekly CNA / HHA Nemployee K, dated w "1/5/12 Blister of Left Tegaderm applied Skintegrity to clean w with Skintegrity, place heel 3 cm still coverer Tegaderm clean ar Boot put on L [left] foot.	videnced a document titled Notes" signature of 3/12, which stated, "1/3/12 8 egaderm patches on [his / bot. 1/3/12 - 9 a. [patient] evere stomach cramps. name] felt like [he / she] vel movement but couldn't. I ] she instructed me to give er he got home from a 9:40 I did give him the pills at 10 videnced a document titled Notes" and signature of eek of 1/2/12, and stated, peech was a little more than normal. [patient] was aning something else I ed Tegaderm patch on his tient] catheter using 30 cc IJ. 1/4/12 6:30 P I replaced in his bottom. I flushed cubic centimeter] as I put [patient] heel pillow on videnced a document titled Notes" with signature of eek of 1/2/12, and stated, heel 3 centimeter, I told by RN [DON] to use ounds Cleaned wound ed new Tegaderm. L [left] d with Tegaderm 1/6/12 and intact heel and coccyx, obt."	N 520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		· '	E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	PROVIDER OR SUPPLIER	DIANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 520	employee L, dated 1/ [catheter] care flush 3  BB. The record "Weekly CNA / HHA employee L, dated w 1/8/12, and stated, "C ready to flush [patien end of cath [catheter]  CC. The record "Weekly CAN / HHA employee L, dated w "1/10/12 Spoke to of acetic acid and oth use acetic acid so mi wrote in spiral as well bowel movement, cle Tegaderm Drove [appointment] . Instruct 1/24 / 7 and dressings changed every three black folder with bind DD. The clinical documentation from 1/11/12 that stated, "Coccyx, pressure ulc W X D(cm) 4.5 X 7.5 # 2 location - left I date acquired 12/29/  EE. The record "Weekly CNA / HHA employee H, dated w "1/11/12 6:00 P V for bed, I noticed bloopenis I flushed [p I reported to [DON]	evidenced document titled Notes" with signature of eek of 1/2/12, Sunday Gave [patient] bath getting t] and little thing on side of broke off."  evidenced a document titled Notes" and signature of eek of 1/9/12, and stated, or RN [DON] about the arrival the supplies. Instructed to for cath [catheter] flush, I 1/11/12 small thaned wound, new to wound care apt. Instructed to go collagen with silver days. Copy of orders in	N 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE IND	IANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 520	flushed catheter using [DON]. 6:30 P I calle [patient] was bleeding had a blister on the 2 penis [DON] told subside and to leave  FF. The record of "Weekly CNA / HHA Nemployee K, dated w "1/12/12 note 2 cron penis 30 cc flus GG. The record "Weekly CNA / HHA Nemployee L, dated wo "On 1/16/12 cath [ca acid 1/17/12 acetic acid. 1/18/12 acetic acid."  HH. The record "Weekly CNA / HHA Nemployee H, dated w "1/18/12 6 P, urine ou [patient] catheter usin [DON]."  II. The record ev "Weekly CNA / HHA Nemployee K, dated w "1/17/12 Multiple BM balls, the rest runny. 1/19/12 no BM ankle 1/20/12 mattress, still needs to	morning 1/14/12 6 PM, g 30 cc as directed by d and informed [DON] that g out of [patient] penis and cm scratch on [patient] me the bleeding should the blister alone."  evidenced a document titled Notes" with signature of eek of 1/9/12, and stated, m in length superficial wound sh with acetic acid."  evidenced a document titled Notes" with signature of eek of 1/16/12, and stated, theter] flush 30 cc acetic cath [catheter] flush 30 cc	N 520			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		012722	B. WING		02/1	7/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
N 520	Continued From page	: 52	N 520			
	"Weekly CNA / HHA Memployee K, dated we"1/19/12 flushed cath acid 1/20/12 [patimattress. min # 5 to g [catheter] with 30 cc a KK. The record of "Weekly CNA / HHA Memployee K, docume and stated, "1/25/12 transported on the wo [appointment]. 2 BM arriving back at house Cleaned 1/26/12 Tegaderm to L heel. (17g) into glass of mil Replaced Tegaderm Cleaned up BM [bowd overnight. [patient] mixed with liquid. Cled dressed and [patient]	ound care apt. liquid while there. Upon e [patient] had a BM liquid. 2 No BM applied Mixed polythylene Glycol k with breakfast 1/27/12 m on (L) heel and coccyx. el movement] liquid from lod second BM solid eaned up. getting [patient] had BM solid and large."				
	"Weekly CNA / HHA Nemployee K, dated w "1/26/12 [patient]	evidenced a document titled Notes" with signature of eek of 1/23/12, and stated, speech trouble finding Ished cath [catheter] with 30				
	"Weekly CNA / HHA Nemployee L, dated we "On 1/27/12 emptied [catheter] at 6:45 PM color 1/28/12 [catheter] care flush verified to 1/29/12 5 - 7 P empties	evidenced a document titled Notes" with signature of eek of 1/23/12, and stated, 200 cc out of [patient] cath urine was dark yellow in 5-7 p done peri / cath w/ 30 cc acetic acid ed 400 cc out of cath d with 30 cc acetic acid."				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU	
AND FLAN	DF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLE	ILED
		012722	B. WING		02/17	7/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DDICUTE:	TAR OF LAFAYETTE IND	25 EXECU	TIVE DRIVE SU	IITE 2A		
DICIOITIO	TAR OF LAFATETTE IND	LAFAYETT	E, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
N 520	Continued From page	e 53	N 520			
	"Weekly CNA / HHA I employee G, dated w "2/1/12 Pt [patient fou possible stroke. drool side of mouth 911 cal	evidenced a document titled Notes" with signature of reek of 1/30/12, and stated, and unresponsive due to ling and gargling on right lled, [DON] called. Sediment e. Paramedics arrived and				
	Physician Progress N that stated, "Labs are leukocytosis with evicurine cultures were of have a UTI this likely altered mental status not be seen." The his Summary" stated, "Rimorning of 2/2/2012, large evolving acute i head and basal gang petechial hemorrhagi Discharge Summary" "Discharge Diagnosis infarct of the right cau ganglia with mass effihemorrhaging. 2) Alti	epeat CT was done on the which, indeed, showed a nfarct in the right caudate lia with mass effect and ng." The "Inpatient Hospital dated 2/2/2012 stated, s: 1) Large evolving acute adate head and basal ect and petechial ered mental status, lethargy, 3) Urinary Tract infection g Foley. 4) Systemic				
	which stated, "To who "[Patient] has been of 2011 He is now v an indwelling cathete which were present w (bilateral sacral). The	evidenced an undated letter om it may concern, ur patient since December 8, wheelchair bound and had r. He has 3 wounds, 2 of when he became our patient third wound is on the ct blister). We have ordered				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
PDICUTE	TAD OF LAFAVETTE IND	25 EXECU	TIVE DRIVE SU	JITE 2A	
БКІОПІЗ	TAR OF LAFAYETTE IND	LAFAYET	TE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE
	yet to arrive. And now he wears at bedtime. is POA [power of attor questions you may hat Florida for the winters transporting [patient]. The letter was signed QQ. The policy to Referral and Admission states, "There must be that the patient's hom adequately met in the Reasonable expectation."	ess from the VA but it has whas pressure relief boots [patient] brother [name] mey] and can answer ave, [POA] are now in so our aides will be to and from appointments." by the DON.  ittled "Section 02.02 - Intake on Acceptance and Criteria" e a reasonable expectation e care needs can be patient's home. In shall consider: 1) as personnel and resources table for providing the equires, 2) The attitudes of			
	care. 3) The patient a willingness to provide agency staffs are not Whether the patient's adequately met in the ongoing availability of and a plan to meet mas whether the physichome are adequate focare."  RR. On Februar director of nursing indevidenced the patient and number after adnidid not evidence the responsible for the dawound care, but the paides were to cover the word willing agency.	vard acceptance of home and / or caregivers ability and interim care when the present, as needed, 5) is needs can be safely and home setting. This includes a personnel and equipment edical emergencies as well earl facilities in the patient's or giving the client proper by 17, 2012, at 3 PM, the licated the documentation by swounds increased in size and size of the plan of care increased were scheduled and all catheter flushes and blan of care indicated the te. She indicated the aides and sift the dressing fell off or next skilled nurse visit, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIR CODE	02/11/2012
		25 EXEC	JTIVE DRIVE SU		
BRIGHTS	TAR OF LAFAYETTE IND	IANA LAFAYET	TE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 520	Continued From page	: 55	N 520		
	week for the first 3 we next 5 weeks, and the of the certification per there were no skilled care to the patient bed December 30, 2012, a weekly thereafter. Sh patient was discharge facility in December 2 sure of the date the Parea and went to Flori				
N 522	410 IAC 17-13-1(a) P	atient Care	N 522		
	written medical plan of periodically reviewed	edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows:			
	interview, the agency treatments that were plan of care for 2 of 3	ord and policy review, and failed to ensure visits and provided followed a written records reviewed of led services (# 's 1 and 3)			
	Findings include:				
	2/5/12, a verbal order "Physical Therapy to week of January 30, 2 document titled "Phys	consent for treatment dated dated 1/30/12 that stated, evaluate and treat starting 2012," evidenced a cical Therapy Evaluation & con & Discharge Summary"			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012
NAME OF PROVIDER	OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BRIGHTSTAR OF	LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
dated The recare we have a care we h	cord failed to e ras developed a vas not a plan of ed that she had tion document.  During a hom tient indicated the sea and those sea and therapy assisty services to the cord of the agency. The sea and	ed by a contracted therapist. vidence a written plan of and implemented.  3 PM, employee E indicated of care developed and a just received the therapy the morning of 2/15/12.  e visit on 2/16/12 at 12 PM, hat employee M completed evaluation and provided PT ervices were planned for nursday. Employee O, a stant, provided physical e patient.  with consent for treatment ed a PT evaluation and thent dated 2/11/12. The nice a written plan of care.  4 PM, employee E indicated of a current patient because information on the patient at a contracted physical the patient's home on At 4:30 PM' employee E aware she had the PT ent and indicated she had evaluation document the evaluation and provided PT enter the provided PT enter the provided physical stant, provided physical	N 522		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		012722	B. WING		02/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTS	TAR OF LAFAYETTE IND	1ΔNΔ 25 EXECU	TIVE DRIVE SU	JITE 2A	
Dittottio		LAFAYET	ΓE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 522	Continued From page 57		N 522		
IN SEE	3. The policy titled "SOrders - Verbal Orde treatments are admin staff only as directed Orders for patient car physician, either verb orders may be taken a verbal order is recewritten down All ospecific order. The othe agency within 24 copy will remain in thorder is returned."  4. The policy titled "SAssessment Visit" staor designated alterna admission visit and or the admission visits are or referral, but may be per patient / family reorders regarding star is to be rendered duriphysician orders will performance of care. visit can be performe evaluate whether hor "hands on" care is proseculated."	section 02.09 Physician rs" states, Policy: Drugs and istered by BrightStar Care by a physician. Procedure: e are obtained from the ally or in writing. Verbal by licensed staff When ived, the order must be orders include: the riginal order is submitted to hours after receipt A e patients record until signed  Section 02.09 - Admission ates, "The supervising nurse te makes the initial eversees the assignment of appropriate personnel. completed with 48 hours of e delayed as documented quest and / or physician to fo care. When skilled care ing the admission visit, be obtained prior to the An admission assessment divincut doctor's orders to the care is needed if no ovided."  My, employee E indicated the renot to contact the she was to obtain the the plan of care, send to the	IN JZZ		
	was returned signed, physicians orders. S	he indicated until the signed hey are operating under the			

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indiana S	tate Department of He	aith				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		012722	B. WING		02/17/2012	
		012722			02/11/2012	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		25 EXECU	TIVE DRIVE SU	JITE 2A		
BRIGHTS	TAR OF LAFAYETTE IND	IAFAYETI	E, IN 47905			
			<u>,                                      </u>			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( /	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
		·		DEFICIENCY)		
			<u> </u>			
N 524	Continued From page	e 58	N 524			
N 524	410 IAC 17-13-1(a)(1	) Patient Care	N 524			
		As follows, the medical plan				
	of care shall:					
	(A) Be developed in	consultation with the home				
	health agency staff.					
	(B) Include all service	es to be provided if a skilled				
	service is being provi	ded.				
	(B) Cover all pertiner					
	(C) Include the follow	_				
	(i) Mental status.	3				
	( )	es and equipment required.				
	• • • • • • • • • • • • • • • • • • • •	duration of visits.				
	(iv) Prognosis.	daration of visits.				
	· ·	otontial				
	` '					
	(vii) Activities permit					
	(viii) Nutritional requi					
	(ix) Medications an					
	• • •	asures to protect against				
	injury.					
		timely discharge or referral.				
	· · ·	ties specifying length of				
	treatment.					
	(xiii) Any other appro	priate items.				
	This RULE is not me	t as evidenced by:				
	Based on clinical reco	ord and policy review and				
		failed to ensure a medical				
		eloped for 2 of 3 clinical				
	records reviewed in w					
		d service. (#'s 1 and 3)				
	p. 37.404 17111 4 0111101	2 55. 1166. (ii 6 1 dild 6)				
	Findings include:					
	i manga maad.					
	1 Clinical record # 1	consent for treatment dated				

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2/5/12, a verbal order dated 1/30/12 that stated,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		012722	B. WING		02/1	7/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU TE, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
N 524	Continued From page	e 59	N 524			
N 324	"Physical Therapy to week of January 30, 3 document titled "Phys Physicians Certification dated 2/5/12 complet The record failed to ecare was developed at the record failed to ecare was not a plant indicated that she have evaluation document.  B. During a hom the patient indicated the physical therapy services and those seevery Tuesday and Tphysical therapy assist therapy services to the 2. Clinical record # 3, dated 2/11/12, included documentation of treater record failed to evide.  A. On 2/15/12 at that patient #3 was no she did not have any and also indicated that therapist had gone to behalf of the agency, indicated she was no evaluation for the pat received the therapy morning of 2/15/12.	evaluate and treat starting 2012," evidenced a sical Therapy Evaluation & on & Discharge Summary" ed by a contracted therapist. evidence a written plan of and implemented.  It 3 PM, employee E indicated of care developed and digust received the therapy the morning of 2/15/12.  In evisit on 2/16/12 at 12 PM, that employee M completed evaluation and provided PT ervices were planned for hursday. Employee O, a stant, provided physical me patient.  With consent for treatment ed a PT evaluation and atment dated 2/11/12. The nnce a written plan of care.  It 4 PM, employee E indicated on a current patient because information on the patient at a contracted physical of the patient's home on At 4:30 PM' employee E t aware she had the PT ient and indicated she had evaluation document the	N 324			
	the patient indicated	ne visit on 2/17/12 at 11 AM, employee M completed the uation and provided PT				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		
		012722	B. WING		02/17/2012	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		25 EXEC	UTIVE DRIVE SI	JITE 2A		
BRIGHTS	TAR OF LAFAYETTE IND	IANA LAFAYE	TE, IN 47905			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	ΓE
N 524	Continued From page	e 60	N 524			
		home visit, employee O, a				
		stant, provided physical				
	therapy services to th	le patient.				
	3 The policy titled "S	Section 02.13 - Clinical				
		ntation" states, "A clinical				
	record will be maintain					
		n services from the agency.				
		ntain at least the following:				
	The medical plan of c	are and appropriate				
	identifying information	n, drug, dietary, treatment				
	and activity orders."					
	4. The policy titled "S	Section 02.14 - Medical Plan				
	of Care, Physician Or					
	<u>-</u>	Medical care shall follow a				
	written medical plan o	of care established and				
	periodically reviewed					
	chiropractor, optomet					
		ation with the agency staff.				
		be provided if a skilled				
	• .	ded. Cover all pertinent				
	Type of services and	e following: Mental status,				
		on of visits, prognosis,				
		II, functional limitations,				
	•	utritional requirements,				
	medications and treat					
		against injury, instructions				
		r referral, therapy modalities				
	specifying length of tr					
		All medications, treatments				
	and services provided					
		n The medical plan of				
		he care plan and will include				
		ble, and realistic goals as				
		tient assessment. The care				
		es rehabilitation potential				
	and discharge plans."					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012	
	ROVIDER OR SUPPLIER	STREET AD 25 EXECU	DRESS, CITY, STA		02/11/2012	
		LAFAYET	TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPL	LETE
N 527	Continued From page	61	N 527			
N 527	410 IAC 17-13-1(a)(2	) Patient Care	N 527			
	promptly alert the per medical component o	The health care ne home health agency shall son responsible for the f the patient's care to any a need to alter the medical				
	This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition or changes that could affect the patient's condition in 1 of 1 clinical records reviewed of patients whose care resulted in patient harm. (#4)					
	Findings include:					
	titled "SK1 - Initial Ski dated 12/8/11 and at employee F, which st hemiparesis, right sid assistive device slin neurologic alert, orien integumentary Skin Abnormalities: 2 unstageable 100 % co record failed to evider	ates, "indwelling catheter, e weakness, use of de board, psycho / ted person, place, forgetful, pressure ulcers Describe c cm [centimeter] byered with slough." The nce the physician was once identified or an order				
	via facsimile on 12/15 physician also dated	ced receipt of a prescription 6/11 from the attending 12/15/11 which stated, "Daily ley flush. Eval + [and] tx ysical therapy] / OT				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	JTIVE DRIVE SU	JITE 2A		
			TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
N 527	Continued From page	e 62	N 527			
	[occupational therapy	] / Speech."				
	"Physician Orders" da employee E which sta Dr. [name] office, spot Informed we had rece care but needed clarit daily nurse visits with [name] a plan of care plans for skilled nursi visit weekly for wound education, and for Foreducation provided to [home health aides] for [name] stated she did to this order and wou to MD. Asked [name] a problem. [name] vee 4. The record eviden "Nursing Clinical Programs of the documented employees wisit between 1 included three documers."	eived the orders for skilled fication on orders regarding daily Foley flush. Informed would be created but that ng visits would be set for 1 d assessment and ley cath [catheter] flush and the patient and HHA's or assistance with the flush. I not think MD would object Id relay this info [information] to call office if this would be erbalized understanding."  ced a document titled gress Notes" dated 12/30/11 oloyee F completed the PM through 1:45 PM and tents titled "Wound Care"				
	A. Document #1 stated, "Wound Location Coccyx midline, type X pressure, assessment date 12/30/11 stage / grade 2 wound in size :0.5 X 0.5 cm exudate none undermining N [no] Tunneling N [no] odor none % Red 100% granulation N periwound					
	(surrounding skin) describe Red blanchable treatment / protocol cleanse soap H 2 O Dressing Tegaderm."					
		stated, "Wound Location X pressure, assessment grade II LXWXD				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED
012722		B. WING		02/17/2012
NAME OF PROVIDER OR SUPPLIER		ESS, CITY, STAT	•	
BRIGHTSTAR OF LAFAYETTE INDIANA	25 EXECUTIV LAFAYETTE,	VE DRIVE SU , IN 47905	IITE 2A	
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
[length, width, depth]: 2.5 X 1.5 ex none undermining N [no] Tunneling odor none % Red 100% granulation periwound (surrounding skin) describe blanchable, treatment / protocol cleans soap cover Tegaderm. Instruction Give relief bony prominence's, discussed heel protectors, patient states does not use at this time if area will [unknown]. Understanding Partial Understanding."  C. Document # 3 stated, "Wound left ankle lateral, type [not indicated] assessment date 12/30/11, stage / grar intact, LXWXD [length, width, depth 2.5 exudate fluid filled not draini undermining N [no] Tunneling N [no] ow granulation N periwound (surrouskin) describe intact, treatment / protocomes to the protector ordered. Patient states will note the protector ordered. Patient states will note the patient's wounds on the coccyx.  5. The record evidenced a document to "Nursing Clinical Progress Notes" date 5:30 AM and indicated the visit was a focument was signed by employee E. document states, "T.C. from patient, stocatheter not draining properly and having Changed Foley inserted without diff obtained yellow cloudy urine with large sediment. Patient states pain relieved catheter change." The record failed to the physician was informed about the curine with sediment.	g N [no] n N Red se H 2 O / en Pressure I use of t want to Verbalized  Location . de blister n]: 2.5 X ing, dor none unding col eels, heel ot wear."  he e status of  citled d 1/2/12 at PRN visit, The ates ng pain ficulty e amount of with evidence cloudy	N 527		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012
	ROVIDER OR SUPPLIER	IANA 25 EXECU	RESS, CITY, STA FIVE DRIVE SU E, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 527	employee E and state change dressing on comicrobial silver dressing manufactures recommodilage. HHA's may be change and report and health status to superphysician signed the rand added a note that coccyx wounds. Pleat [name]."  7. The record evident CNA / HHA Notes" with dated week of 1/9/12, note 2 cm in length sum 30 cc flush with act to evidence the physic wound on penis.  8. On February 17, 2 nursing indicated that indicated that the patisize and number after not have any other dot that the attending physic that the attending size and the size and siz	lated 1/4/12 and signature of ed, "Request orders to occyx wounds to an anting every 5 days per nendations, and PRN for oe trained and able to y changes to patient's visor." The attending request and dated 1/4/12 to stated, "I was not aware of se arrange consult with Dr.  ced document titled "Weekly th signature of employee K, and stated, "1/12/12 uperficial wound on penis. etic acid." The record failed cian was notified of the	N 527		
N 533	developed by a regist of delegating nursing provided through the	nursing plan of care must be ered nurse for the purpose directed patient care home health agency for y home health aide services	N 533		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BOILDING.		
		012722	B. WING		02	2/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
BRIGHTS'	TAR OF LAFAYETTE IND	1ΔNΔ 25 EXEC	CUTIVE DRIVE SU	ITE 2A		
	TAR OF EATATETIE IND	LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
N 533	Continued From page	e 65	N 533			
	(b) The nursing plan following: (1) A plan of care and identifying information (2) The name of the (3) Services to be produced in the produced in the frequency and (5) Medications, diet. (6) Signed and dated personnel providing some (7) Supervisory visits (8) Sixty (60) day sure (9) The discharge not identified in the following states of the following sure in the followin	of care must contain the d appropriate patient n. patient's physician. ovided. nd duration of visits. , and activities. d clinical notes from all services. s. mmaries.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		SURVEY PLETED	
		012722	B. WING	B. WING		2/17/2012
					02	11112012
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
BRIGHTS	TAR OF LAFAYETTE IND	IANA	JTIVE DRIVE SU	IITE 2A		
	T	LAFAYEI	TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
N 533	Continued From page	e 66	N 533			
	titled "Initial Phone Ca FORM" which indicate called the agency Oc "Had a stoke in May, side, can move and s need someone eveneed someone full tin for Florida."	, evidenced a document all Assessment - INTAKE ed the a family member tober 20, 2011 and states, has hemiparesis on right tandup but can dress self, ery day get down, get up, ne, because family leaves				
	A. The record evidenced documents titled "Weekly CNA / HHA Notes." The record evidenced employee K, home health aide, provided services to the patient on behalf of the agency on 12/8/11 beginning at 8 AM.					
	"SK1 - Initial Skilled C 12/8/11 and at 5 PM, home health aide, wh catheter, hemiparesis of assistive device neurologic alert, orien	nted person, place, forgetful, pressure ulcers Describe 2 cm [centimeter]				
	"PC2 / SS2 - Aide / H Plan of Care" dated 1 assigned was a home that were assigned to were hygiene - bed - shampoo hair as nee shave electric as nee dressing daily, cathet feeding, and turning a	e health aide. The services be performed by the aide partial / complete daily, ded, mouth care daily,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE INI	DIANA	CUTIVE DRIVE SUIT	E 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 533	Continued From pag	e 67	N 533			
	indicated the home hand provided service the patient because the signed physician  3. Clinical record #5 of 12/8/11, failed to ecare. The clinical retitled "PC2 / SS2 - Ai Companion Plan of CA. The clinical reprovided aide service P provided aide	Care" dated 11/1/11.  record evidenced employee G es on 12/14/11 and employee ices on 12/8/11, 12/9/11, 12/14/11, 12/15/11, 12/16/11, 12/21/11, 12/23/11, and at 10:20 AM, employee E				
	the previous informa admission. There wa	was a readmit and she used tion from the 11/1/11 as not an assessment by the or to the aide rendering care.				
	indicated she used a identified as "PC2 / S Companion Plan of C care and the service care services. She in plan for clinical record	PM, the Director of Nursing in agency document SS2 - Aide / Homemaker / Care" as the nursing plan of agreement for attendant indicated the nursing care at # 2 did not include all the nat there was no further				
	of Care" states, "A no developed by a regis	Section 02.11 - Nursing Plan ursing plan of care must be stered nurse for the purpose g directed patient care				

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	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/17/2012	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
N 533		home health agency for y home health aide services	N 533			
N 540	are limited to therapy	A) Except where services only, for purposes of nealth setting, the registered owing:	N 540			
	This RULE is not met as evidenced by: Based on clinical record and policy review, and interview, the agency failed to ensure the registered nurse made an initial assessment visit to identify the patients' immediate care needs as required by agency policy for 3 (#'s 1, 3, and 5) of 5 clinical record reviewed.  Findings include:					
	1/30/12 and a physicistated, "Physical Theistarting week of Janufailed to evidence an completed within 48 hreceiving the referral. incomplete assessment employee M, the physical states of the states	The record evidenced an				
	2/6/12 and a physicia stated, "Request orde	evidenced a referral dated n order dated 2/6/12 that ers for Physical Therapy to rting week of 2/6/12." The				

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012722 B. WING 02/1	7/2012
012122 027	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 540  Continued From page 69  record failed to evidence an initial assessment visit was completed within 48 hours of the agency receiving the referral.  3. Clinical record # 5, first date of patient care 12/8/11, failed to evidence an initial assessment by the registered nurse. The clinical record evidenced a document titled "PC2 / SS2 - Aide / Homemaker / Companion Plan of Care" dated 11/1/11.  A. The clinical record evidenced employee G provided aide services on 12/14/11 and employee P provided aide services on 12/14/11 and employee P provided aide services on 12/14/11, 12/16/11, 12/12/11, 12/13/11, 12/14/11, 12/15/11, 12/13/11, 12/14/11, 12/13/11, 12/13/11, 12/14/11, 12/13/11, 12/13/11, and 12/24/11.  B. On 2/17/12 at 10:20 AM, employee E indicated the patient was a readmit and she used the previous information from the 11/1/11 admission. There was not an assessment by the registered nurse prior to the aides rendering care.  4. The undated policy titled "Section 02.09 - Admission Assessment Visit" stated, "An initial assessment must be completed with the identification of patient needs before home care services can be rendered. The supervising nurse or designated alternate makes the initial admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visit and oversees the assignment of the admission to the appropriate personnel. Admission visit and per patient / family request and / or physician orders regarding start of care An admission visit can be performed without doctor's orders to evaluate whether home care is needed of no "bands on" care is provided."	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
		012722	B. WING		02	/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	UTIVE DRIVE SUIT TTE, IN 47905	E 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 540	Skilled Nursing Servinurses do the followin assessments."  6. On February 15, 2 E indicated the initial completed within a w  7. On February 16, 2 indicated she did not any patient's home to	y titled "Section 02.10 - ces" stated, "Registered ng: Perform initial admission 2012, at 11:21 AM, employee assessment was to be eek of the physicians' order. 2012, at 10 AM, employee E send skilled disciplines to evaluate for services until ved signed physician orders	N 540			
N 542	Rule 14 Sec. 1(a) (1) are limited to therapy practice in the home nurse shall do the foll (C) Initiate the plan or revisions.  This RULE is not me Based on clinical recobservation, and inte ensure the registered care for 4 of 5 clinical 3, and 5)  Findings include:  1. Clinical record # 1 dated 2/5/12, include 1/30/12 that stated, "evaluate and treat states."	of care and necessary	N 542			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BRIGHTS	TAR OF LAFAYETTE IND	IANA	ΓΙVE DRIVE SU E, IN 47905	JITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 542	completed by a contrafailed to evidence the completed and initiate.  A. On 2/15/12 at there was not a plan of had just received the document the morning.  B. During a home the patient indicated of physical therapy evaluservices and those seevery Tuesday and The visit, employee O, a provide physical therapy evaluservices and those seevery Tuesday and The visit, employee O, a provide physical therapy evaluservices and those seevery Tuesday and The visit, employee O, a provide physical therapy evaluation and the care was 2/13/12, fail registered nurse had a plan of care.  On 2/17/12 at 1 Findicated she used an identified as "PC2 / S Companion Plan of Coare and as the service care services. She incoplan for clinical record required items and the documentation.	rge Summary" dated 2/5/12 acted therapist. The record registered nurse had ad a plan of care.  3 PM, employee E indicated of care developed and she therapy evaluation g of 2/15/12.  e visit on 2/16/12 at 12 PM, employee M completed the uation and provided PT evices were planned for nursday. During the home hysical therapy assistant, apy services.  first date the aide provided ed to evidence the developed and implemented  PM, the Director of Nursing agency document S2 - Aide / Homemaker / are" as the nursing plan of the agreement for attendant dicated the nursing care I # 2 did not include all the tere was no further  with consent for treatment and adocument titled aluation & Physicians	N 542		
	2/11/12. The record f plan of care.	ailed to evidence a written			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BRIGHTS'	TAR OF LAFAYETTE IN	DIANA	UTIVE DRIVE SUIT	ΓE 2A		
		LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 542	patient indicated emphysical therapy evaservices. During the physical therapy ass therapy services to to the services. During the physical therapy ass therapy services to to the services the	visit on 2/17/12 at 11 AM, the ployee M completed the aluation and provided PT a home visit, employee O, a sistant, provide physical he patient.  5, first date the aide provided illed to evidence the developed and implemented of developed and implemented of developed and implemented of the state of the services from the 11/1/11 as not a plan of care gistered nurse.  Section 02.13 - Clinical entation" states, "A clinical entation" states, "A clinical entation the services from the agency entain at least the following: care and appropriate on, drug, dietary, treatment orders, and Medical Plan orders, and Medical "Medical care shall follow a of care established and	N 542	DEFICIENC	<u> </u>	
	Include all services to service is being providiagnosis. Include the Type of services and frequency and durat	tation with the agency staff. to be provided if a skilled wided. Cover all pertinent the following: Mental status, d equipment required, tion of visits, prognosis, al, functional limitations,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE IND	DIANA 25 EXEC	ADDRESS, CITY, STATE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ITTE, IN 47905  ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 542	medications and trea measures to protect of for timely discharge of specifying length of the appropriate items and services provide ordered by a physicial care will be used as the reasonable, measured determined by the paplan will also address and discharge plans.  7. The policy titled "Sof Care" states, "A nudeveloped by a regist of delegating nursing provided through the	autritional requirements, tments, any safety against injury, instructions or referral, therapy modalities reatment, any other. All medications, treatments d to patients must be an The medical plan of the care plan and will include able, and realistic goals as attent assessment. The care sees rehabilitation potential ""  Section 02.11 - Nursing Plan ursing plan of care must be tered nurse for the purpose directed patient care home health aide services	N 542			
N 546	Rule 14 Sec. 1(a) (1) are limited to therapy practice in the home nurse shall do the fol (G) Inform the physic medical personnel of condition and needs, family in meeting nur participate in inservice and teach other nurs.  This RULE is not measured based on clinical recommendation and measured teach other nurs.	cian and other appropriate changes in the patient's counsel the patient and sing and related needs, the programs, and supervise ing personnel.	N 546			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		, ,	E SURVEY PLETED
		012722	B. WING		02	2/17/2012
	PROVIDER OR SUPPLIER	DIANA 25 EXEC	DDRESS, CITY, STATE UTIVE DRIVE SUIT ITE, IN 47905	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
N 546	informed the physicial condition or changes patient's condition in reviewed of patients patient harm. (#4)  Findings include:  1. Clinical record #4 titled "SK1 - Initial Sk dated 12/8/11 and at employee F, which st hemiparesis, right sid assistive device slineurologic alert, orier integumentary Skin Abnormalities: 2 unstageable 100 % crecord failed to evide notified of the wound for treatment was obtained assistive device with facsimile on 12/15 physician also dated nurse visits. Daily For [treatment] for PT [phreatment] for PT	an of changes in the patient's that could affect the 1 of 1 clinical records whose care resulted in 4, evidenced a document illed Client Assessment" 5 PM, completed by tates, "indwelling catheter, de weakness, use of ide board, psycho / inted person, place, forgetful, pressure ulcers Describe 2 cm [centimeter] covered with slough." The ince the physician was once identified or an order tained by the nurse.  Inced receipt of a prescription 5/11 from the attending 12/15/11 which stated, "Daily bley flush. Eval + [and] tx inspical therapy] / OT y] / Speech."  Inced a document titled ated 12/15/11 written by ated, "T.C. [telephone call] to be with [name] RN. eived the orders for skilled iffication on orders regarding in daily Foley flush. Informed a would be created but that ing visits would be set for 1	N 546			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY. STATE, JP CODE 25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47995    CACH CEPTICANON MUST BE PRECEDED BY TRUL.   PRETRY (ACAH CORRECTIVE AUTON SHOULD BE CONNECTED BY TRUL.   PROVIDED BY TRUL.   PROVIDED BY TRUL.   PRETRY (ACAH CORRECTIVE AUTON SHOULD BY TRUL.   PRETRY (ACAH CORRECTIVE AUTON SHOULD BY TRUL.   PRETRY (ACAH CORRECTIVE AUTON SHOULD BY TRUL.   PROVIDED BY TRUL.   PRETRY (ACAH CORRECTIVE AUTON SHOULD BY TRUL.   PROVIDED BY TRUL.   PRETRY (ACAH CORRECTIVE AUTON SHOULD BY TRUL.   PROVIDED BY TRUL.   PROV	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JP CODE  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905    MAYOR   D							
SUMMARY STATEMENT OF DEFICIENCIES   LAFAYETTE, IN 47905   PREPRIX   TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREPRIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREPRIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREPRIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREPRIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE			012722	B. WING		02/1	17/2012
CASTELLE NO FLAFACTETE INDIANA   CAPACITE INDIANA	NAME OF PI	ROVIDER OR SUPPLIER					
N 546   SUMMANY SIXTELENT OF DEFICIENCES   PREFIX   REQUIATORY OR LSC IDENTIFYING INFORMATION)   TAG	BRIGHTS	TAR OF LAFAYETTE IND	IANA		JITE 2A		
education provided to the patient and HHA's [home health aides] for assistance with the flush. [name] stated she did not think MD would object to this order and would relay this info [information] to MD. Asked [name] to call office if this would be a problem. [name] verbalized understanding."  4. The record evidenced a document titled "Nursing Clinical Progress Notes" dated 12/30/11 that documented employee F completed the nurse visit between 1 PM through 1:45 PM and included three documents titled "Wound Care Flow Sheet."  A. Document #1 stated, "Wound Location Coccyx midline, type X pressure, assessment date 12/30/11 stage / grade 2 wound in size 10.5 X 0.5 cm exudate none undermining N [no] Tunneling N [no] dor none % Red 100% granulation N periwound (surrounding skin) describe Red blanchable treatment / protocol cleanse soap H 2 O Dressing Tegaderm."  B. Document #2 stated, "Wound Location right coccyx, type X pressure, assessment date 12/30/11 stage / grade II LXWXD [length, width, depth]: 2.5 X 1.5 exudate none undermining N [no] Tunneling N [no] odor none % Red 100% granulation N periwound (surrounding skin) describe Red blanchable, treatment / protocol cleanse H 2 O / soap cover Tegaderm. Instruction Given Pressure relief borny prominence's, discussed use of heel protectors, patient states does not want to use at this time if area will [unknown]. Verbalized	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
C. Document # 3 stated, "Wound Location	N 546	education provided to [home health aides] for [name] stated she did to this order and would to MD. Asked [name] a problem. [name] volume a problem	o the patient and HHA's or assistance with the flush. I not think MD would object Id relay this info [information] to call office if this would be erbalized understanding."  ced a document titled gress Notes" dated 12/30/11 ployee F completed the PM through 1:45 PM and tents titled "Wound Care  stated, "Wound Location X pressure, assessment grade 2 wound in size date none unneling N [no] odor none % ation N periwound scribe Red blanchable leanse soap H 2 O  stated, "Wound Location X pressure, assessment grade II LXWXD 2.5 X 1.5 exudate g N [no] Tunneling N [no] 0% granulation N ng skin) describe Red t / protocol cleanse H 2 O / n. Instruction Given Pressure ce's, discussed use of int states does not want to a will [unknown]. Verbalized I Understanding."	N 546			

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		012722	B. WING		02	/17/2012
	ROVIDER OR SUPPLIER  TAR OF LAFAYETTE INC	DIANA 25 EXEC	ADDRESS, CITY, STATE CUTIVE DRIVE SUIT ETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 546	intact, LXWXD [le 2.5 exudate flu undermining N [no] T granulation N skin) describe intact, Tegaderm. Instruction protector ordered. Particular protector ordered. Par	and stage / grade blister ength, width, depth]: 2.5 X and filled not draining, funneling N [no] odor none periwound (surrounding treatment / protocol in Given Protect heels, heel atient states will not wear."  alled to evidence the was informed of the status of on the coccyx.  Inced a document titled gress Notes" dated 1/2/12 at end the visit was a PRN visit, do by employee E. The C. from patient, states properly and having pain serted without difficulty dry urine with large amount of ates pain relieved with the record failed to evidence formed about the cloudy.  Inced a document titled dated 1/4/12 and signature of end, "Request orders to coccyx wounds to an anti	N 546			

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Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPL	
		012722	B. WING		02/1	7/2012
	ROVIDER OR SUPPLIER	IANA 25 EXECU	DRESS, CITY, STA TIVE DRIVE SU TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
N 546	CNA / HHA Notes" wi dated week of 1/9/12, note 2 cm in length st 30 cc flush with act to evidence the physi wound on penis.  8. On February 17, 2 nursing indicated that indicated that the patisize and number after not have any other do that the attending phy the increasing size ar	ced document titled "Weekly th signature of employee K, and stated, "1/12/12 uperficial wound on penis. etic acid." The record failed cian was notified of the	N 546			
N 547	Rule 14 Sec. 1(a) (1)(are limited to therapy practice in the home I nurse shall do the foll (H) Accept and carry podiatrist, dentist and and written).  This RULE is not me Based on clinical recointerview, the agency registered nurse carri which were obtained evaluation of the patie in 3 of 3 clinical recorwhich received skilled.  Findings include:	nealth setting, the registered owing: out physician, chiropractor, optometrist orders (oral  t as evidenced by: ord and policy review and failed to ensure the ed out the physician orders	N 547			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/1	7/2012
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
N 547	1/30/12 that stated, "evaluate and treat stated 2012" and evidenced Therapy Evaluation & Discharge Summary" a contracted therapis evidence any other evany other discipline overbal order was not 2. Clinical record #3 dated 2/6/12 that state physical therapy eval of 2/6/12." The record titled "Physical Thera Certification & Discha 2/11/12. The record evaluation was compor a reason to explair not carried out.  3. Clinical record #4 received on 10/20/11 receiving skilled servifacility. Consents for signed by the power of 12/8/11. The Services ame day with the selisted as "CNA [certification in the services." A verbal of attending physician for services and was date evidenced a plan of codate 12/15/11.  4. On 2/16/12 at 2:50	ed a verbal order dated Physical Therapy to arting week of January 30, a document titled "Physical Physicians Certification & dated 2/5/12 completed by t. The record failed to valuation was completed by r a reason to explain why the carried out.  included a verbal order es, "Request order for uation and treatment week d evidenced a document apy Evaluation & Physicians arge Summary" dated railed to evidence any other leted by any other discipline why the verbal order was  evidenced the referral was when the patient was ces in a skilled nursing home care services were	N 547			

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Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  N 547  Continued From page 79  N 547  A. BUILDING:  B. WING PREFIX TAG B. WING PREFIX CITY, STATE, ZIP CODE  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  N 547  N 547  Continued From page 79	(X3) DATE SURVEY COMPLETED	CONSTRUCTION	` ′	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	FOF DEFICIENCIES OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER  BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE, IN 47905  ID PROVIDER'S PLAN OF CORRECTION (X COMPONENTS)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY)	-	A. BUILDING.				
BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION (X COMPRETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY)	02/17/20 <sup>-</sup>		B. WING	012722		
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   DEFICIENCY   DEF		TE, ZIP CODE	DRESS, CITY, STA	STREET ADD	ROVIDER OR SUPPLIER	NAME OF P
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (X COMPACTION SHOULD BE COMPACTION SHOULD BE COMPACTION SHOULD BE DEFICIENCY)  COMPACT TAG DEFICIENCY		JITE 2A		IANA	TAR OF LAFAYETTE IND	BRIGHTS
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			1E, IN 4/905			
N 547 Continued From page 79 N 547	RECTIVE ACTION SHOULD BE COPERING THE RENCED TO THE APPROPRIATE	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
			N 547	e 79	Continued From page	N 547
physicians for any skilled services until the physician order was signed and returned to the agency and that was why the patients did not have skilled services and evaluations timely as she was waiting for the physician's signature.  5. On 2/17/12 at 2.40 PM, employee E indicated there was not an agency policy or procedure that specified how the agency was to determine the start of care date.  6. The policy titled "Section 02.09 Physician Orders - Verbal Orders" states, Policy: Drugs and treatments are administered by BrightStar Care staff only as directed by a physician. Procedure: Orders for patient care are obtained from the physician, either verbally or in writing. Verbal orders may be taken by licensed staff When a verbal order is received, the order must be written down All orders include: the specific order. The original order is submitted to the agency within 24 hours after receipt A copy will remain in the patients record until signed order is returned."  7. The policy titled "Section 02.09 - Admission Assessment Visit" states, "The supervising nurse or designated alternate makes the initial admission visit are completed with 48 hours of referral, but may be delayed as documented per patient / family request and / or physician orders regarding start of care. When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care."			N 547	lled services until the signed and returned to the why the patients did not and evaluations timely as the physician's signature.  PM, employee E indicated incy policy or procedure that ency was to determine the section 02.09 Physician rs' states, Policy: Drugs and istered by BrightStar Care by a physician. Procedure: the are obtained from the ally or in writing. Verbal by licensed staff When inved, the order must be orders include: the riginal order is submitted to thours after receipt A the patients record until signed section 02.09 - Admission of the patients record until signed section 02.09 - Admission of the propriate personnel. Sompleted with 48 hours of the delayed as documented quest and / or physician of care. When skilled care ing the admission visit, the obtained prior to the	physicians for any ski physician order was sagency and that was shave skilled services she was waiting for the sage specified how the age start of care date.  6. The policy titled "S Orders - Verbal Order treatments are adminstaff only as directed Orders for patient carphysician, either verborders may be taken a verbal order is receive written down All of specific order. The order is returned."  7. The policy titled "S Assessment Visit" start or designated alternate admission visit and ow the admission visits are or referral, but may be per patient / family recorders regarding start is to be rendered duriphysician orders will be serviced.	N 547

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (			(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED	
		012722	B. WING		02/17	7/2012	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DDIOLITO	FAD OF LAFAVETTE IND	25 EXECU	TIVE DRIVE SU	JITE 2A			
BRIGHTS	TAR OF LAFAYETTE IND	LAFAYETT	E, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
N 562	Continued From page	e 80	N 562				
N 562	410 IAC 17-14-1(c) S	cope of Services	N 562				
	listed in subsection (b (1) make an initial e	e appropriate therapist b) of this rule shall: evaluation visit to the patient by services are required;					
	This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the physical therapist completed the initial assessment visit within forty eight hours of referral as required by agency policy in 2 of 2 clinical records reviewed of patients receiving physical therapy only. (# 1 and 3)						
	Findings include:						
	1. Clinical record # 1, consent for treatment dated 2/5/12, included a verbal order dated 1/30/12 that stated, "Physical Therapy to evaluate and treat starting week of January 30, 2012" and a document titled "Physical Therapy Evaluation & Physicians Certification & Discharge Summary" dated 2/5/12 completed by a contracted therapist. The record failed to evidence the therapy evaluation was completed within 48 hours.						
	dated 2/6/12 that state physical therapy evalue of 2/6/12." The record titled "Physical Thera Certification & Dischat 2/11/12. The record f						

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012722	B. WING		02/1	7/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE IND	IANA 25 EXECU	DRESS, CITY, STA TIVE DRIVE SU TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 562	she did not carry out in physicians for any skill physician order was sagency and that was have skilled services was waiting for the phyerbal order before sediscipline.  4. The policy titled "Sassessment Visit" state or designated alternated admission visit and on the admission visits are or referral, but may be per patient / family recorders regarding start is to be rendered duri	D PM, employee E indicated the verbal orders from lled services until the signed and returned to the why the patients did not and evaluations timely. She hysician's signature on the ending out a skilled  Section 02.09 - Admission at the signed and returned to the hysician's signature on the ending out a skilled  Section 02.09 - Admission at the signal at the signa	N 562			
N 572	by the home health as a social worker, or a set the supervision of a secondance with the result. This RULE is not measured as a contained interview, the agency social worker provide.	y social services furnished gency, shall be provided by social work assistant under ocial worker, and in medical plan of care.	N 572			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILDING			
		012722	B. WING		02	/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	UTIVE DRIVE SU TE, IN 47905	JITE 2A		
	OUR MARRY OF		<u> </u>	DDOL/(DEDIO DI AM OF	000000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 572	Continued From page	e 82	N 572			
	"Home Health Certific Treatment" dated 12/ identified the patient I right flaccid hemipare diagnosis of CVA after for "MSW [medical so assist." The record fat provided services to the 2. Personnel file A, a hire 11/1/11 and first patient # 4, failed to et the qualifications of a 19-9-25 defined a so "means a person who	15/11 through 02/12/12 that had a principle diagnosis of esis and an addition ercare and included orders ocial worker] - eval and iled to evidence the MSW the patient.  I social worker (SW), date of patient contact 1/14/12 with evidence the employee met social worker. 410 IAC cial worker and stated, o has a master's degree all work accredited by the				
	2. On February 16, 2012, at 10 AM, the director of nursing indicated she did not send any skilled disciplines to the patient homes until the physician had signed the verbal order and it was returned to the agency.					
		5 PM, the director of nursing r the SW on the plan of care order."				
	social worker were pr 11/1/11, 11/13/11, and patient's start of care assisted the patient / in the skilled nursing residence.	l evidenced services of the rovided to this patient on d 11/21/11, prior to the . The notes indicate the SW family, while the patient was facility, to find the patient a				
		ates, "The supervising nurse				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		012722	B. WING		02	/17/2012
	ROVIDER OR SUPPLIER TAR OF LAFAYETTE IND	IANA 25 EXEC	DDRESS, CITY, STAT UTIVE DRIVE SUI ITE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
N 572	the admission to the a Admission visits are of referral, but may be per patient / family re- orders regarding start is to be rendered duri physician orders will be performance of care. visit can be performed	te makes the initial versees the assignment of appropriate personnel. completed with 48 hours of de delayed as documented quest and / or physician t of care. When skilled care ing the admission visit, oe obtained prior to the An admission assessment d without doctor's orders to ne care is needed if no	N 572			
N 596	be responsible for encontact, the individual aide services on its boof this section as follows:  (1) The home health (A) have successfull evaluation program the subjects listed in substitution.  This RULE is not me Based on personnel redocument review and to ensure, prior to pataides successfully co	e home health agency shall suring that, prior to patient Is who furnish home health ehalf meet the requirements ws: a aide shall: by completed a competency hat addresses each of the section (h) of this rule; and at as evidenced by: record, clinical record, and I interview, the agency failed tient contact, home health mpleted a competency a 6 of 6 home health aide	N 596			
	_	w on 2/15/12 at 12:50 PM, s indicated she completed				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  25 EXECUTIVE DRIVE SUITE 2A  LAFAYETTE IN 47905  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (FROULATORY OR LSC IDENTIFYING INFORMATION)  N 596  Continued From page 84  all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient.  2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number.  3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program"		T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL TAG  (X4) ID PREFIX TAG  COntinued From page 84  all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient.  2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number.  3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program"	AND PLAN	PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING: COMPL		COMPLETED		
BRIGHTSTAR OF LAFAYETTE INDIANA  25 EXECUTIVE DRIVE SUITE 2A LAFAYETTE, IN 47905    CACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS   CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    N 596   COntinued From page 84     all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient.    2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number.    3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program"			012722	B. WING		02/17/2012
CAPACETTE IN AT905   SUMMARY STATEMENT OF DEFICIENCIES   CAPACETTE (N 47905   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   COMPLETE   DATE   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   COMPLETE   DATE   DEFICIENCY   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETE DATE    N 596   Continued From page 84	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 596  Continued From page 84  all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient.  2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number.  3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program"	BRIGHTS	TAR OF LAFAYETTE IND	IANA		JITE 2A	
all competency evaluations for the Home Health Aides in facilities. She further indicated that she does not test the aides on range of motion, active or passive, and the nurses are not to order any aides to complete range of motion without an order for a therapist to evaluate the patient.  2. On 2/16/12 at 4:35 PM, employee N, the human resource officer, indicated the governing body of the agency requested the Indiana State Department of Health to close the previously operated home health agency and then they applied for a new home health agency provisional license on 12/1/11 and received that license which was dated 12/8/11. She indicated the personnel files that were presented for review were from that previous agency and she did not realize this was a new agency with a new license number.  3. The policy titled "Section 03.07 - Staff In-services, Home Health Aide Continuing Education, and Competency Evaluation Program"	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE COMPLETE
states, "Home Health Aides prior to providing patient service should have the following areas addressed: Successful completion of a competency evaluation program Have documentation which demonstrates successful completion of a competency evaluation."  4. The policy titled "Section 03.13 - Clinical Competency Program" states, "BrightStar Care will access and document the clinical competency of each staff member who provides direct client care, treatment, or services. Each staff member who provides direct client care will have a clinical competency assessment at defined intervals: a. as part of orientation, in accordance with laws and regulations."	N 596	all competency evalual Aides in facilities. Shous not test the aide or passive, and the maides to complete ran order for a therapist to the competency experience of the competency respectively. On 2/16/12 at 4:35 human resource officibody of the agency respectively of the agency respectively operated home health applied for a new hon license on 12/1/11 and which was dated 12/8 personnel files that wwere from that previous realize this was a new number.  3. The policy titled "Sin-services, Home Health patient services, Home Health patient service shoul addressed: Successful competency evaluated documentation which completion of a competency Program will access and documentation of each staff member care, treatment, or see who provides direct of competency assessmas part of orientation,	ations for the Home Health lee further indicated that she les on range of motion, active lurses are not to order any luge of motion without an loo evaluate the patient.  5 PM, employee N, the leer, indicated the governing lequested the Indiana State luto close the previously luto agency and then they luto agency and then they luto agency and she did not luto agency and she did not luto agency and she did not luto agency with a new license licerton 03.07 - Staff lealth Aide Continuing luto betency Evaluation Program luto Aides prior to providing lutompletion of a luton program Have luto demonstrates successful luto luto luto luto luto luto luto luto	N 596		

Indiana State Department of Health

Indiana State Department of Health

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	)
		012722	B. WING	<del></del>	02/17/20	012
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER					
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU	JITE 2A		
		LAFAYET	TE, IN 47905			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		OMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
N 596	Continued From page	85	N 596			
	Continuou i rom page	. 60				
		H, I, J, K, and L included the				
	document titled "Com	petency Assessment Skills				
	Check List for Certifie	d Nursing Assistant." The				
	skills included on the	_				
		thermometers, oral, axillary,				
		!) Pulse - radial. 3) Pulse -				
		sure. 5) respirations., 6)				
	1 -	bed bath. 8) skin care. 9)				
		•				
		oo. 11) toileting / elimination:				
		de commode. 12) transfer:				
	bed to chair, chair to	•				
		r. 13) assists with range of				
		devices: walker, cane, other.				
	15) positioning. 16) m	aking occupied bed. 17)				
	Miscellaneous skills:	Medication reminder,				
	Urinary catheter care	, gastrostomy site care,				
	observe / record intak	ce / output, other, and other.				
		tion: feeding, diabetic diet,				
	,	esterol / fat diets." The form				
		d dated by the individual				
		The proficiency method code				
	at the bottom of the p					
		emonstration, and "ST" for				
		list did not include range of				
	motion.					
	6 Porconnol filo C	late of hire 6/3/11 and first				
		late of hire 6/3/11 and first				
	patient contact 12/14/	•				
		ent titled "Competency				
	Assessment Skills Ch					
	_	at documented skills were				
	· ·	, 8/31/11, 12/7/11, and				
	1/10/12 (after patient	contact). The document				
	failed to evidence the	aide was evaluated on 1)				
	range of motion, 2) sh	nower or tub bath, 3)				
		al preparation, diabetic, low				
		rol /fat diets. The document				
		as evaluated as competent				
		and written in as "catheter				

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flush" that was not dated. This task is not in the

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17/2012
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU E, IN 47905	JITE 2A	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
N 596	scope of practice of the 7. Personnel file H, dipatient contact 12/13/evidenced the docum Assessment Skills Ch. Nursing Assistant" the evaluated on 6/7/11, and 12/30/11 (after fir document failed to evidenced on 1) range bath, 3) shampoo, 4) urinal, bedpan, or bed meal preparation of a cholesterol / fat diet. the aide was evaluate additional task and wiflush" on 12/13/11 and 12/20/11. These task practice of the home is 8. Personnel file I, da patient contact 12/11/evidenced the docum Assessment Skills Ch. Nursing Assistant" where valuated on 10/20/11 (after patient contact) evidence the aide was motion, 2) shower or elimination, urinal, be and 4) meal preparation sodium, or low choles document evidenced competent in an addit "Foley catheter flush" 12/18/11. These tasks practice of the home is practice of the home is practice of the home is patient.	late of hire 5/18/11 and first 11 with patient # 4, ent titled "Competency leck List for Certified at documented skills were 6/8/11, 8/31/11, 12/13/11, st patient contact). The idence the aide was e of motion, 2) shower or tub toileting or elimination, diside commode, and 5) diabetic, low sodium, or low The document evidenced at as competent in an ritten in as "Foley catheter d "basic wound care" s are not in the scope of health aide.  Attent titled "Competency leck List for Certified hich documented skills were 1, 12/11/11, and 12/18/11 The document failed to s evaluated on 1) range of tub bath, 3) toileting or dpan, or bedside commode, on of a diabetic, low sterol / fat diet. The the aide was evaluated as ional task and written in as and "basic wound care" on s are not in the scope of	N 596		

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Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	COMPLETE		
		012722	B. WING		02/1	7/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DDICUTE:	TAD OF LAFAVETTE IND	25 EXECU	TIVE DRIVE SU	JITE 2A		
БКІВПІЗ	TAR OF LAFAYETTE IND	LAFAYET	TE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
	Assessment Skills Ch Nursing Assistant" wh evaluated on 11/1/11, document failed to ev evaluated on 1) range bath, 3) shampoo, 4) urinal, bedpan, or bed feeding, or meal prep low cholesterol / fat d evidenced the aide w in an additional task a catheter flush" and "b 12/24/11. These task practice of the home in 10. Personnel file K, patient contact 12/24/ evidenced the docum Assessment Skills Ch	ent titled "Competency neck List for Certified nich documented skills were 11/9/11, and 12/24/11. The idence the aide was e of motion, 2) shower or tub toileting or elimination, dside commode, and 4) aration of a low sodium, or iet. The document as evaluated as competent and written in as "Foley asic wound care" and dated as are not in the scope of health aide.  date of hire 6/22/11 and first //11 with patient # 4, ent titled "Competency				
	evaluated on 7/8/11, 12/15/11. The docum aide was evaluated or shower or tub bath, 3 elimination, bedpan, of feeding, or meal prep sodium, or low choles document evidenced competent in an addit "Foley catheter flush" dated 12/15/11. These of practice of the hom 11. Personnel file L, of first patient contact 12 document titled "Com Check List for Certifies."	9/8/11, 12/8/11, and nent failed to evidence the n 1) range of motion, 2) ) shampoo, 4) toileting or or bedside commode, and 4) aration of a diabetic, low sterol / fat diet. The the aide was evaluated as tional task and written in as and "basic wound care" and se tasks are not in the scope				

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		012722	B. WING		02/17	//2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	ΓΙVE DRIVE SU E, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
N 596	evaluated on 1) range bath, and 3) toileting of bedside commode. T aide was evaluated a task and written in as "basic wound care" at	to evidence the aide was to evidence the aide was to of motion, 2) shower or tub or elimination, bedpan, or the document evidenced the scompetent in an additional "Foley catheter flush" and had dated 12/30/11. These cope of practice of the home	N 596			
N 598	shall maintain docum demonstrates that the subsection and subsermet.  This RULE is not me Based on personnel redocument review and to ensure documenta patient contact, home completed a compete of 6 home health aide and L).  Findings include:  1. During an interview the Director of Nurses all competency evaluated in facilities. She does not test the aide or passive, and the nurse order for a therapist to	The home health agency entation which e requirements of this ection (h) of this rule were	N 598			

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	SURVEY
	012722	B. WING	<del> </del>	02	17/2012
NAME OF PROVIDER OR SUPPLIE	R ST	REET ADDRESS, CITY, STATE	E, ZIP CODE	·	
BRIGHTSTAR OF LAFAYETT	Ε ΙΝΠΙΔΝΔ	EXECUTIVE DRIVE SUIT	TE 2A		
DRIGHTOTAK OF EAFAIETT	LA	AFAYETTE, IN 47905			
PREFIX (EACH DEFI	IRY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
body of the ager Department of Hoperated home is applied for a new license on 12/1/which was dated personnel files the were from that prealize this was number.  3. The policy tith In-services, Home Education, and of states, "Home Hopatient services addressed: Succompetency evadocumentation with completion of a state of each staff median care, treatment, who provides discompetency assas part of oriental and regulations.  5. Employee file document titled of Check List for Coskills included of Temperature - discourse in the care, treatment, who provides discourse titled of the care of the c	e officer, indicated the governing acy requested the Indiana State lealth to close the previously health agency and then they whome health agency provision 11 and received that license is 12/8/11. She indicated the hat were presented for review revious agency and she did not a new agency with a new licens led "Section 03.07 - Staff the Health Aide Continuing Competency Evaluation Program lealth Aides prior to providing should have the following areas cessful completion of a alluation program Have which demonstrates successful competency evaluation."  Ited "Section 03.13 - Clinical competency who provides direct client or services. Each staff member exect client care will have a clinical essment at defined intervals: a lation, in accordance with law "  Item (Section Care will have a clinical essment at defined intervals: a lation, in accordance with law "  Item (Section Care will have a clinical essment at defined intervals: a lation, in accordance with law "  Item (Section Care will have a clinical essment at defined intervals: a lation, in accordance with law "  Item (Section Care will have a clinical essment at defined intervals: a lation, in accordance with law "  Item (Section Care will have a clinical essment at defined intervals: a lation, in accordance with law "  Item (Section Care will have a clinical essment at defined intervals: a lation, in accordance with law "	e cy rall . s			

Indiana State Department of Health

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		012722	B. WING		02/1	7/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
BRIGHTS	TAR OF LAFAYETTE IND	IANA	TIVE DRIVE SU TE, IN 47905	JITE 2A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	) BE	(X5) COMPLETE DATE
N 598	urinal, bedpan, bedsic bed to chair, chair to ambulation, and othe motion. 14) assistive 15) positioning. 16) m Miscellaneous skills: Urinary catheter care observe / record intak 27) Meal Prepara low sodium, low chole was to be initialed an evaluating the skill. The at the bottom of the probservation, "D" for dispecial training. The motion.  6. Personnel file G, copatient contact 12/14, evidenced the docum. Assessment Skills Ch. Nursing Assistant" the evaluated on 6/21/11 1/10/12 (after patient failed to evidence the range of motion, 2) shampoo, and 4) measodium, low cholester evidenced the aide win an additional task affush" that was not dascope of practice of the contact 12/13, evidenced the docum. Assessment Skills Ch. Nursing Assistant" that was sistant that evidenced the docum. Assessment Skills Ch. Nursing Assistant that the contact 12/13, evidenced the docum. Assessment Skills Ch. Nursing Assistant that the contact 12/13, evidenced the docum.	de commode. 12) transfer: standing, assist with r. 13) assists with range of devices: walker, cane, other. haking occupied bed. 17) Medication reminder, hat output, other, and other. hitton: feeding, diabetic diet, hat dated by the individual he proficiency method code hat dated by the individual hat of hire 6/3/11 and first hat diet of hire 6/3/11 and first hat documented skills were hat documented skills were hat documented skills were hat document hat document hat diets. The document hat diets. The document has evaluated as competent hand written in as "catheter hat diets. The document has evaluated as competent hat written in as "catheter hat diets. This task is not in the hat home health aide.  Hate of hire 5/18/11 and first hat with patient # 4, hent titled "Competency	N 598			

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STATE FORM 8899 S93011 If continuation sheet 91 of 94

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		012722	B. WING		02	2/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
BRIGHTS'	TAR OF LAFAYETTE INC	DIANA	CUTIVE DRIVE SUIT	ΓE 2A		
Bidoillo	TAR OF EAFAIETTE INC	LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 598	document failed to every evaluated on 1) rang bath, 3) shampoo, 4) urinal, bedpan, or be meal preparation of a cholesterol / fat diet. the aide was evaluate additional task and w flush" on 12/13/11 and 12/20/11. These task practice of the home  8. Personnel file I, dipatient contact 12/11 evidenced the document Assessment Skills CI Nursing Assistant" with evaluated on 10/20/1 (after patient contact evidence the aide was motion, 2) shower or elimination, urinal, be and 4) meal preparate sodium, or low choles document evidenced competent in an addi "Foley catheter flush" 12/18/11. These task practice of the home	rst patient contact). The vidence the aide was e of motion, 2) shower or tub toileting or elimination, dside commode, and 5) a diabetic, low sodium, or low The document evidenced ed as competent in an vitten in as "Foley catheter of "basic wound care" is are not in the scope of health aide.  ate of hire 10/10/11 and first //11 with patient # 4, nent titled "Competency heck List for Certified hich documented skills were 11, 12/11/11, and 12/18/11 or las evaluated on 1) range of tub bath, 3) toileting or edpan, or bedside commode, sion of a diabetic, low sterol / fat diet. The the aide was evaluated as itional task and written in as "and "basic wound care" on its are not in the scope of health aide.	N 598			
	evidenced the docum Assessment Skills CI Nursing Assistant" wi evaluated on 11/1/11 document failed to ev evaluated on 1) rang	nent titled "Competency heck List for Certified hich documented skills were , 11/9/11, and 12/24/11. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED	
		012722	B. WING		02	/17/2012
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
PRICUTE	TAR OF LAFAVETTE IN	DIANA 25 EXEC	CUTIVE DRIVE SUIT	ΓΕ 2A		
БКІВПІЗ	TAR OF LAFAYETTE IN	LAFAYE	TTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 598	feeding, or meal prelow cholesterol / fat evidenced the aide vin an additional task catheter flush" and "12/24/11. These tas practice of the home 10. Personnel file K patient contact 12/24 evidenced the docur Assessment Skills C Nursing Assistant" we evaluated on 7/8/11, 12/15/11. The docur aide was evaluated shower or tub bath, selimination, bedpan, feeding, or meal presodium, or low choled document evidenced competent in an add "Foley catheter flush dated 12/15/11. The of practice of the hor 11. Personnel file L, first patient contact 1 document titled "Cor Check List for Certific documented skills we The document failed evaluated on 1) rangibath, and 3) toileting bedside commode. aide was evaluated at task and written in as	edside commode, and 4) paration of a low sodium, or diet. The document vas evaluated as competent and written in as "Foley basic wound care" and dated ks are not in the scope of health aide.  , date of hire 6/22/11 and first 4/11 with patient # 4, ment titled "Competency heck List for Certified which documented skills were 9/8/11, 12/8/11, and ment failed to evidence the on 1) range of motion, 2) 3) shampoo, 4) toileting or or bedside commode, and 4) paration of a diabetic, low esterol / fat diet. The d the aide was evaluated as itional task and written in as " and "basic wound care" and ese tasks are not in the scope	N 598			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		012722	B. WING		02/17/2012
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
BRIGHTS	TAR OF LAFAYETTE IND	ΙΔΝΔ	TIVE DRIVE SU	JITE 2A	
DIXIGHTS	IAN OF LAFATETTE IND	LAFAYET	E, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 598	Continued From page	93	N 598		
	health aide.				
	nearth alde.				
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